

The Modern Hospital

**AUGUST
1953**

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June 20, 1875—July 19, 1953

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The Modern Hospital

AUGUST 1953

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2. There Were Only Minor Flaws in St. Vincent's Disaster Plan

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Artificial Kidney Is a Lifesaver

JOHN E. KILEY, M.D., and
THOMAS HALE Jr., M.D.

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FRASER D. MOONEY, M.D.

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AMONG THE AUTHORS

Among the hospital and public health administrators, medical executives and practicing physicians taking part in the Hill-Burton survey reported in this issue were several whose answers, for one reason or another (in most cases because they came too late, or because they didn't want their comments published) are not included in the summary beginning on page 47. These were the following: Dr. Elwood W. Mason, Milwaukee, internist; Melvin C. Schefflin, secretary of the Association of Western Hospitals; Gordon R. Cumming, California State Health Department; Dr. Harry C.



Smith, Manchester, N. H.; **Murphy Cole**, Anniston, Ala.; **Hiram Sibley**, secretary, Connecticut Hospital Association; **Margaret Lamb**, Norman, Okla.; **Benjamin Wright**, Wilmington, Del.; **C. M. Austin**, Sioux Falls, S.D.; **Harry C. Wheeler**, Billings, Mont.; **Crayton E. Mann**, Evansville, Ind.; **Kenneth L. Winters**, Portville, N.Y.; **John W. Gill**, Vicksburg, Miss.; **Frank S. Groner**, Memphis, Tenn.; **J. G. Carr Jr.**, Casper, Wyo., and **Dr. Fraser D. Mooney**, Buffalo, N.Y.

A. C. O'Connor, assistant director of Mt. Sinai Hospital, Cleveland, entered the hospital field in 1927 at the Mayo Clinic after graduation from the Rochester Junior College, Rochester, Minn. He was in private business from 1936 until he entered the army in 1946. Mr. O'Connor was formerly the administrator of the Newark and Middletown, Ohio, hospitals.



Harry C. Bach, co-author with Mr. O'Connor of the nursing article on page 74, is administrator of the Mary Washington Hospital, Fredericksburg, Va. A graduate of the course in hospital administration at Northwestern University, Chicago, Mr. Bach served an administrative residency at Springfield City Hospital, Springfield, Ohio. He was then assistant administrator at Middletown Hospital, Middletown, Ohio, for almost four years prior to going to Fredericksburg.



Lauretta Paul, who wrote the article on appraisals on page 77, is director of Pontiac General Hospital, Pontiac, Mich. Originally a public accountant, Miss Paul did systems work and procedural consulting for hospitals, as a member of an accounting firm, switching into hospital administration in her present position several years ago. She is a vice president of the Michigan Hospital Association and a trustee of Michigan Blue Cross.

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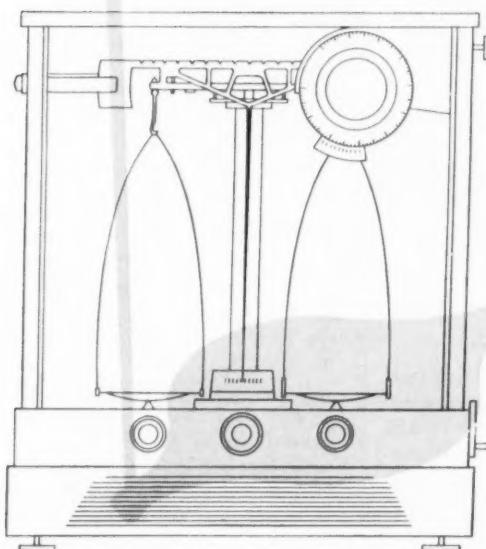
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Reader Opinion

Statement Misquoted

Sirs:

In the May issue of The MODERN HOSPITAL, an account is given of the Mid-West Hospital Association convention in which a talk I gave on "Patients are People" was misquoted.

My intention was to let it pass without comment but it has just come to

my attention that my statements, as printed, have caused some reverberations and adverse criticism.

You quoted me as saying, "So often nurses spend the first few days of a patient's stay creating a hostile attitude in the patient, and then spend the rest of the time complaining about this attitude." Had I said this, it would indeed

have been a serious charge; although only a few words were changed, my actual statement had an entirely different meaning.

I said, "Because we make his decisions and plan his activities, we are likely to spend the first few days of the patient's hospitalization making him too dependent and the rest of his stay complaining about it." I am sure you will agree that this is an entirely different thing. The statement preceded some examples of how we do the patient's thinking for him and when he has come to accept this and is convalescing, we suddenly withdraw the attention and wonder why he seems so dependent.

The second quotation referred to our tendency to fit the patient into our routine and do his thinking for him, and I said, "As an individual personality, the patient is at a disadvantage as soon as he enters the hospital."

I do want to thank you for the fine coverage the meetings received. The fact that my brief comments were discussed here in Nebraska speaks well for the care with which The MODERN HOSPITAL is being read.

S. Margery Jarmon,
Director of Nurses

Bishop Clarkson Memorial Hospital
Omaha, Neb.

Better Than Depreciation

Sirs:

Mr. Weiner's article on the topic "Should Hospitals Use Public Funds for Private Patients?" warrants comment.

It is true that most hospitals do not include depreciation among their expense but it is likewise true that the same hospitals charge replacement of equipment and to quite some extent reconstruction of facilities to their budgetary expenditure. Therefore, items which are considered capital expenditure and which would have to be charged against the depreciation reserve (if it exists) are taken into account when the current cost of hospital operation is computed.

Depreciation accounting is good accounting. However, it can be replaced by a well conceived replacement, maintenance and reconstruction budget which should be accounted for within the hospital's over-all budget. If this is done, budget and accounts give a proper basis for the setting of private and semiprivate rates. Cost will not be computed below reality and rates can be established so as to avoid the use of

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charitable funds for nonindigent patients.

Depreciation accounting should only be introduced by voluntary hospitals if the hospital actually sets aside cash or security funds corresponding with the provisions for depreciation. These funds should then be used for capital outlay. As long as depreciation reserves are not funded in this way, depreciation accounting is not very meaningful for institutions that are exempt from income tax. As a matter of fact, it may lead to an inflation of the cost picture because I am quite sure that in such

instances many replacement and reconstruction expenditures will continue to be charged to cost over and above the depreciation charge. I, therefore, strongly recommend in lieu of depreciation accounting a well conceived capital budget to be integrated with the accounting for the normal operating budget of the hospital unless actual depreciation funds can be set aside.

Incidentally, one kind of charitable contribution is collected all over the country which definitely and by purpose serves not only the indigent patient. This is the contribution toward

a hospital building fund. Every contributor knows that the voluntary hospital he helps to construct will be a facility not only for the indigent but also to a very large extent for those patients who can afford to pay fully for required hospital services.

Frederick Grubel, C.P.A.
Maimonides Hospital
Brooklyn, N.Y.

Trap Those Bobby Pins

Sirs:

Your correspondent L.O.B., Mont., who complains of difficulty in keeping the sinks open in his nurses' residence halls because "women permit their hair and bobby pins to go down the drain" may overcome his difficulty by fitting special traps under the sinks which incorporate a receptacle for foreign matter. I enclose an illustration of this type of trap which is used almost universally in hotels and hospitals in this country and, I have no doubt, a similar device is available in the United States.

E. William Bull
Deputy Supplies Officer
Leeds (A) Group Hospital
Management Committee
Leeds 9, Yorkshire, England

Sirs:

I noticed the letter in your March 1953 issue of *The MODERN HOSPITAL* under the "Small Hospital Questions" section. The subject was "Her Hair-Bobby Pin Problem" sent in by L.O.B. of Mont., and I would like to give you my idea of solving the problem of bobby pins causing obstructions in the wash basins in nurses' residence halls or any other residences for women. My suggestion is to have the top portion of the outlet made of a magnetized metal. Any bobby pins or other metal objects which could cause the sewer to be stopped up would immediately adhere to the outlet with the major portion projecting and thus allowing for quick removal.

H. Louis Shapiro
Medical Supply Officer A.J.D.C.
Paris, France

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Roving Reporter

Innovations Abound at Kaiser Hospital

Happier nurses and happier patients—perhaps even happier visitors—seem fairly well assured at the new seven-story Kaiser Foundation Medical Center in Los Angeles. Opened officially June 17, the 224 bed hospital overlooking Barnsdall Park, the city, and the coastal mountains should make conversation wherever hospital administrators, architects and patients gather.

Of the innovations the most interesting undoubtedly is the separate corridor idea. The hospital wings each have three separate corridors: one is a central work corridor containing decentralized nurses' stations and two are outside corridors for visitors. This means that the patients' visitors never tangle with hospital personnel in traffic congested corridors and that the patients' needs can be attended to without interference.

Visitors walk along one of the two outer corridors and enter patients' rooms through sliding glass doors opening onto these outer corridors. This cuts the risk of outside contamination, collisions and irritations.

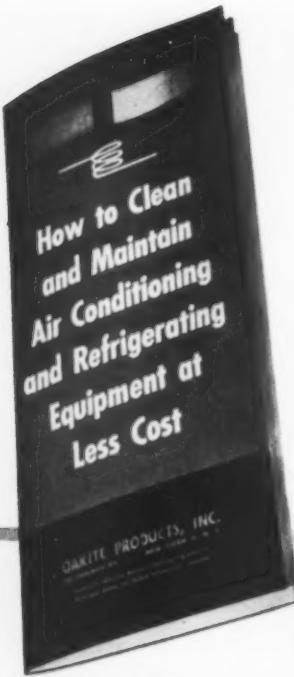
The central corridor is devoted solely to the work of the physicians, nurses and other hospital personnel. Rather than having the conventional single station for all nurses on a particular floor, individual stations—one for every four rooms or eight patients—have been established in the work corridors. Drugs, medications, x-ray

plates and viewing boxes, instruments, charts, and diet instructions for each patient are kept at his particular station not many steps away from his bed. At the door into each room from the work corridor are service shelves for linens and food trays, and a built-in clothes hamper. Spaced between each nursing station are utility units containing cabinets, sinks, sterilizers, refrigerator and hot plates.

The work corridor and decentralized nurses' stations provide more efficient service and allow closer observation of the patient. The nurses' walking is reputed to be reduced to one-seventh that of conventional floor plans, so that the nurses are able to remain close to the patient and offer faster service. Attending physicians are aided by having the charts, medications and treatment records clearly in view just outside each patient's door.

A supervisor at a control station on each floor handles the routing of visitors down the outer corridors, as well as the incoming and outgoing requisitions from hospital personnel via intercommunication systems. Materials from the hospital's central storeroom, pharmacy, laboratory, record room, central supply or business office are requested and delivered from this point by mechanical conveyors.

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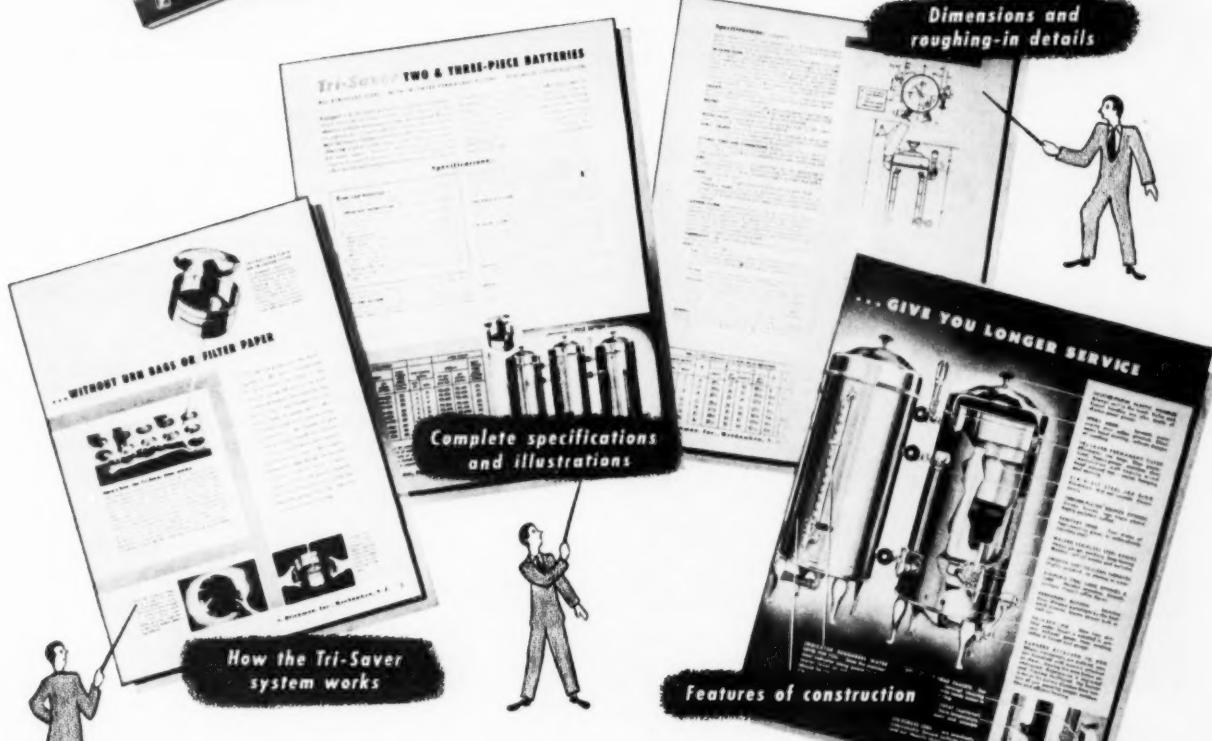


Exterior of the Kaiser Foundation Medical Center, Los Angeles.



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service devices to make the patient's hospital stay comfortable and pleasant. Beds are of the electric-motor type with back, knee and height adjustments which the patient himself can control by push button.

Alongside each bed, within reach of the patient, is a built-in cabinet containing a lavatory with hot, cold and ice water taps, and four-channel radio and phonograph outlets. There is piped oxygen at each bedside. Each room contains individual toilets and clothes closets.

The walls separating the rooms



Convalescent patients enjoy the luxuries of the recreation room.



Central corridor for personnel; visitors use outer corridors.

from the outer corridors are glass from floor to ceiling, affording the patient more sunlight and a cheerful atmosphere. Draperies are operated electrically from the patient's bedside to permit complete privacy from the outer corridor, and blinds may screen a patient from the neighboring patient in a two-bed room.

Rooms on the top floors of the medical center offer hotel service for convalescents. As soon as patients become ambulatory, they are moved to these rooms, where, in pleasant surroundings removed from acutely ill patients, they complete their stay. These patients may eat in a buffet-style dining room, participate in social recreation, watch television programs, and sleep late in the morning, psychological aids to recovery.

The maternity department follows the living-in plan. A private nursery is located adjacent to the mother's room at the head of her bed but separated by a soundproof wall.

The infant's plastic bassinet rests in a steel drawer built into the wall between the mother's room and the nursery; it may be pulled to the mother's bedside at bed level as simply as one pulls a drawer from a desk. Linen and other supplies needed for the infant's care are stored in the drawer ready for use.

When the mother, after feeding and observing her child, wishes to rest, she pushes the bassinet drawer back into the nursery, at which time a light automatically signals the nurse to take charge. The mother can always look at her child through a tall window built in just above the drawer.

Many of the hospital innovations have been developed out of more than 20 years' experience of Dr. Sidney R. Garfield, director of Kaiser Foundation hospitals, with Henry J. Kaiser working closely on the planning. The architects were Wolff & Phillips.



FOUR TITUSVILLE TDL 3-DRUM BOILERS

ARE THE HEART OF THE INSTITUTION!



Architects-Engineers—Skidmore, Owings & Merrill
General Contractor—Caudwell-Wingate Company
Heating Contractor—Jarcho Brothers

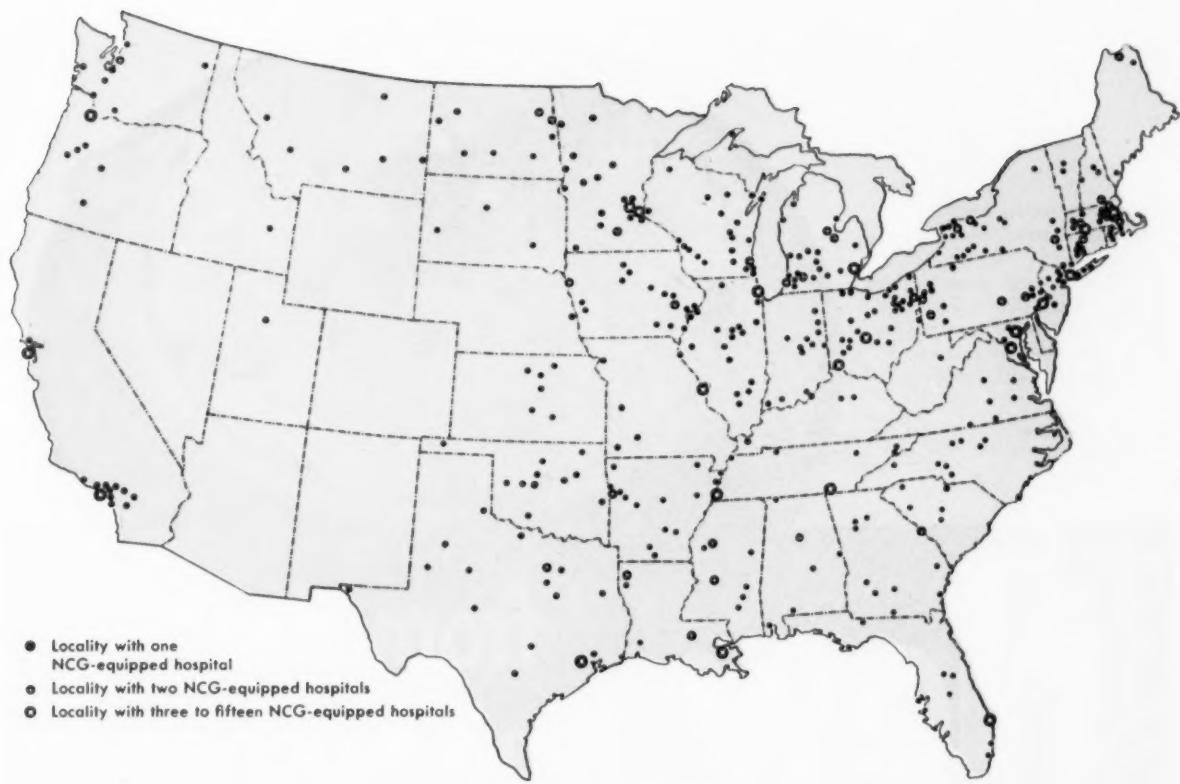
The safety and comfort of patients and staff in the new 1000-bed Veterans Hospital at Fort Hamilton, Brooklyn, N.Y. are guarded continuously by four Titusville 3-drum TDL Water Tube Boilers, of 390 normal horsepower each. Chosen for work-horse reliability the year around, these units take care of all heating needs of main buildings and laundry. Write for Bulletin No. B-3200A.



A division of

Sruthers
Wells

THE TITUSVILLE IRON WORKS CO.
TITUSVILLE, PA.
Manufacturers of
A COMPLETE LINE OF BOILERS FOR
EVERY HEATING AND POWER REQUIREMENT



Now! More than 500 U. S. Hospitals Use NCG Oxygen Piping Equipment

The map above locates more than 500 hospitals that have oxygen piping systems in which NCG equipment is used.

This figure is particularly remarkable when you realize that it represents *a greater number than the total of all U. S. hospitals* that were reported two years ago as having piped oxygen systems.

This is significant in two ways:

1. It emphasizes the strong trend to piped oxygen. Comparatively rare a few years ago, it is now accepted as the method of choice in supplying oxygen. Hospitals have found that it is more convenient, more economical and permits more effective use of inhalation therapy.
2. It is a graphic indication of the leadership in this field conferred upon NCG by hospitals and hospital architects—a leadership won by equipment of excellent design and construction, and a planning and advisory service that has proved most helpful to hospital executives, architects and builders.

You can easily get the facts about an oxygen piping system for your hospital, whether for new or existing buildings, NCG will gladly survey your requirements and give you estimates and preliminary plans—with no cost or obligation to you.

Why not take advantage of this expert advice based on practical experience with over 500 hospitals of all sizes and types? Phone or write to your nearest NCG branch, or to the address below.

NCG®

MEDICAL SERVICES

NATIONAL CYLINDER GAS COMPANY, MEDICAL DIVISION

840 N. Michigan Avenue • Chicago 11, Illinois

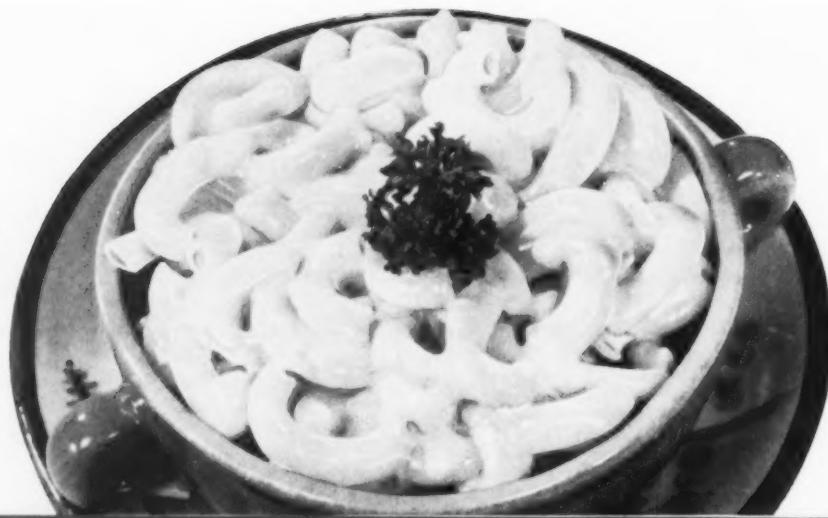
Offices in 54 cities

Copyright 1953, National Cylinder Gas Company



Visit the NCG exhibit at the A. H. A. Convention in San Francisco

MACARONI AND CHEEZ WHIZ. Measure 1 cup of Cheez Whiz from the can for each pound of hot cooked well drained macaroni. Toss lightly. Serve in individual hot casseroles. Garnish with parsley.



New from the Kraft Kitchen...

Cheez Whiz is a "Natural" for preparing

•CHEESEBURGERS

•MACARONI

•TOASTED CHEESE SANDWICHES

•WELSH RABBIT

•VEGETABLE DISHES

•CASSEROLE DISHES

Newest product of the Kraft Kitchen is Cheez Whiz, a pasteurized process cheese spread, which is perfect for preparing many cheese dishes. Smooth, creamy-thick, rich Cheez Whiz offers you these advantages:

Faster and easier to use—

No need to cut and melt sections of cheese when you want to fix cheese dishes. Cheez Whiz is ready to use just as it comes from the can. *Eliminates costly preparation time.*

More economical—

Cheez Whiz is convenient to use and gives you the added advantage of economy. You'll find it will cost you less than any serving of cheese.

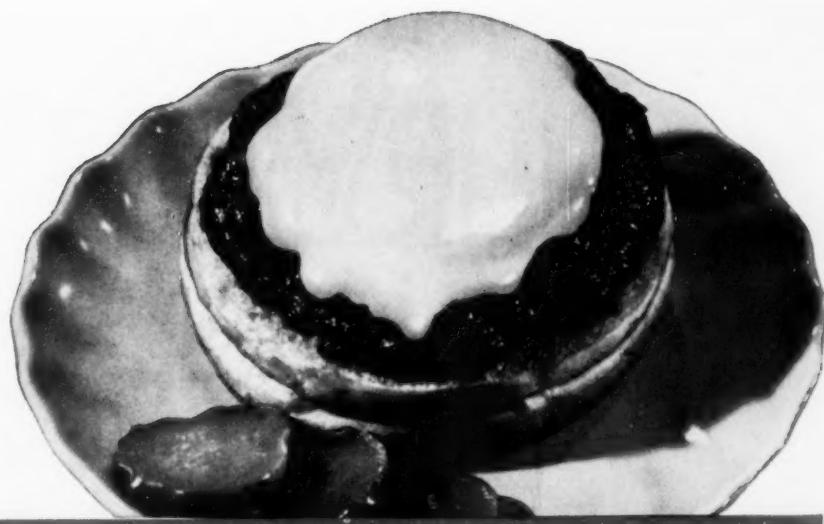
Tops in quality—

Cheez Whiz is the result of careful development and thorough testing in the Kraft Kitchen. It is backed by the "know-how" which has produced such outstanding food products as Miracle Whip, Kraft Ribbon Slices and PC Packs.



HAMBURGERS WITH

CHEEZ WHIZ. Spoon, or scoop Cheez Whiz (with a Number 40 scoop) onto hot hamburgers.



Cheez Whiz

FOR CHEESE DISHES FAST!



CHEEZ WHIZ RABBIT. Melt Cheez Whiz in a double boiler or steam table. Pour over toast triangles and garnish with paprika.

Packed in #10 tin—6½ lbs.



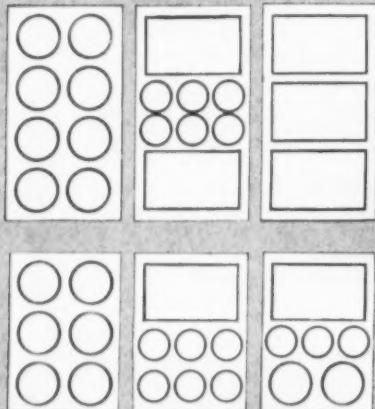
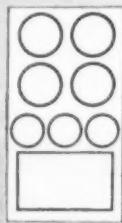
The Nation's Taste is
your best Buying Guide

SERVHOT[®]

A NEW NAME IN THE FOOD CONVEYOR FIELD...



Seven models provide utensil arrangements, and equipment to meet any hospital feeding requirement and to serve both standard and special diets for 35, 50, 55 or 60 persons. All Servhot conveyors are built to make possible easy installation of an extra end shelf when desired.



Food serving equipment especially designed and built to make Swartzbaugh quality available to hospitals with limited budgets.

Servhot is a new low-priced food conveyor engineered and manufactured to the same exacting standards of precision and quality found in all other products of this company, and equally guaranteed. Bridge-type top deck construction, ball bearing, rubber tired casters, 6-inch (extra deep) well for meat, steel and rubber bumper, perfected heat units and controls—these and other exclusive Swartzbaugh features are embodied in every Servhot unit.

Mass production economies and a drastic simplification of design enable this great specialized factory to sharply cut costs of Servhot conveyors, and these savings are passed on to the hospital.

Any hospital, however small its bed capacity or budget, can easily afford Servhot conveyors. They render the same labor and food saving service as other Swartzbaugh equipment and give the same long life of dependable, trouble-free performance.

Ask your hospital supply dealer or write for complete specifications and price data.



MADE ONLY
BY THE

Swartzbaugh

MANUFACTURING COMPANY
ESTABLISHED IN 1884

TOLEDO 6, OHIO

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You can buy sutures more wisely if you know fine furniture



Here comes some good old "rockin' chair" logic.

No furniture can be better than the wood it's made from. Well-seasoned, straight-grained solid wood is as strong at the heart as it is on the surface. Compare this to an inexpensive veneer.

There can be "veneer" in catgut sutures, too — when suture surfaces are stronger than their centers. Natural catgut is strengthened and given added resistance to absorption when it is chromicized. To be uniformly absorbable, a suture must be uniformly chromicized — all the way through.

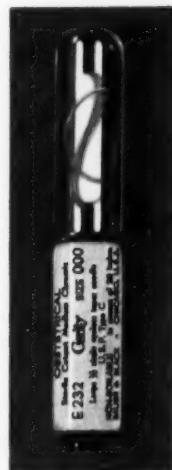
Total, even chromicization — as in the new *Curity 2-bath method* — builds dependable absorption performance in sutures. For further dependability, *Curity Sutures* are chromicized only after catgut plies have

been firmly bonded into strands by *natural gut mucin*. This method requires no foreign bonding agent.

The modern *Curity Chromic Suture* is another better tool of surgery — from the laboratory which has made major contributions to suture making.

Curity
REG U.S. PAT OFF
SUTURES

(BAUER & BLACK)
DIVISION OF THE KENDALL COMPANY
309 W. Jackson Blvd., Chicago 6



At last an inexpensive underpad that can't leak through

*New Curity Incontinent
Pad with plastic bottom sheet
saves linen, laundry and money*

The biggest hospital money saver in years! Savings in linen, nurse time and laundry more than pay for these new Curity underpads with *waterproof plastic bottom sheets*. And they cost no more than old-style paper and fiber underpads!

New Skintex top sheet lets drainage penetrate immediately to absorbent inner layers. Wet or dry, Skintex feels like skin, promotes patient comfort . . . 39% stronger, too, more tear-resistant than regular paper top sheets. Soft, fluffy absorbent filler is 60% thicker and holds more drainage than any comparable underpad. For added comfort and extra protection, waterproof plastic bottom sheet has "traction," won't slide from under patients.

Order new Curity Incontinent Pads today. Let them start paying for themselves in savings now!

NEW
Curity
REG. U.S. PAT. OFF.
INCONTINENT PAD

(BAUER & BLACK)

Division of The Kendall Company
309 West Jackson Blvd.
Chicago 6, Illinois

**FILLED WITH WATER FOR
7 DAYS**, new Curity Incontinent Pad showed no sign of leakage or vapor permeation. Liquid was immediately absorbed and retained. In tests, ordinary paper and fiber pads leaked through in a matter of minutes.



Upjohn

**mixed
surface
infections...**

Each gram contains 5 mg. neomycin sulfate (equivalent to 3.5 mg. neomycin base).

Available: Ointment in $\frac{1}{2}$ oz. and 1 oz. tubes, and 4 oz. jars. Cream in $\frac{1}{2}$ oz. tubes.

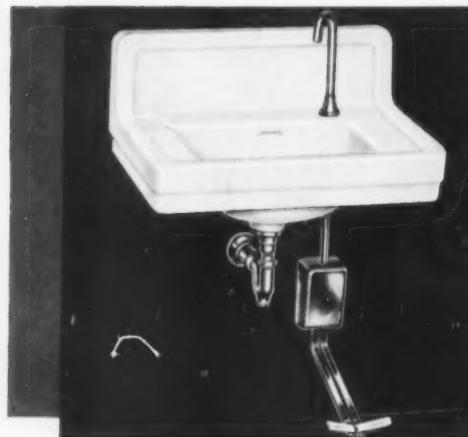
THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN



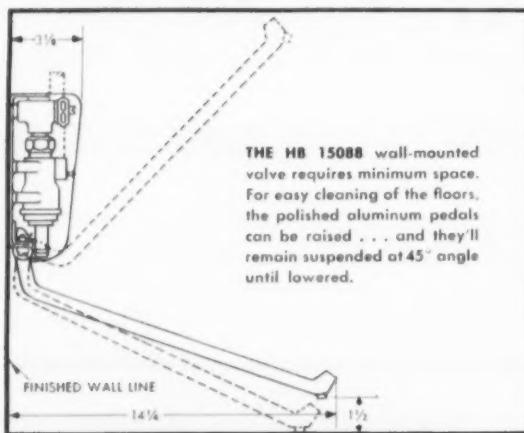
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Trademark Reg. U.S. Pat. Off.

CREAM OR
OINTMENT



HF 12145 P vitreous china lavatory with HB 15088 pedal valve and type N tempered supply line. This valve is ideal for use with surgeons' scrub-up sinks and other lavatories, too.

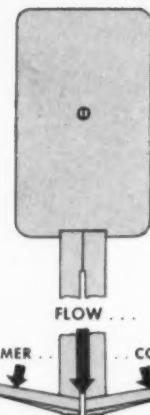


THE HB 15088 wall-mounted valve requires minimum space. For easy cleaning of the floors, the polished aluminum pedals can be raised . . . and they'll remain suspended at 45° angle until lowered.



HF 13411 VP GLENCO TOILET is shown with HB 15334 foot valve bedpan cleanser assembly. Pedal valve can also be specified for other closets and clinic service sinks.

**Angled pedals
permit one-foot control
of water flow
and water temperature**



without lifting your foot

**. . . with this new
Double-Pedal
Mixing Valve**

Angled pedals make this new wall-mounted, foot-operated valve more convenient to use. One foot controls both water flow and water temperature, leaving hands *completely* free.

With this new pedal design, the heel acts as a pivot. Light pressure on one pedal starts flow of hot water, pressure on the other a supply of cold water. An even down-pressure produces tepid water. You get maximum water flow with only 1 1/2" pedal travel.

This new self-closing valve brings welcomed convenience to many fixtures. With a bedpan cleanser, for instance, it eliminates fussing with other valves. Water is controlled solely by the foot pedals. When pedals are released, water automatically shuts off . . . no pressure is left in the hose.



AMERICAN-Standard

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Penna.

Serving home and industry

AMERICAN-STANDARD • AMERICAN BLOWER • CHURCH SEATS & WALL TILE • DETROIT CONTROLS • KEWANEE BOILERS • ROSS EXCHANGERS

TOPPER PAD

TRADE MARK

... a new postoperative dressing
SAVES UP TO 60%



Johnson & Johnson
HOSPITAL DIVISION



Pediatric
Erythrocin stearate
TRADE MARK
(ERYTHROMYCIN STEARATE, ABBOTT)

Oral Suspension

ESPECIALLY RECOMMENDED

against staphylococcal, streptococcal, pneumococcal infections

ESPECIALLY ADVANTAGEOUS

in children sensitive to other antibiotics or when
the causative organism is resistant to them

SUPERIOR

because it is less likely to alter the normal intestinal flora than
other oral antibiotics, except penicillin

Offering a new advantage

in antibiotic therapy, *Pediatric ERYTHROCIN Oral Suspension* provides
the effectiveness of ERYTHROCIN in a sweet, cinnamon-flavored form.
There's no problem in administration—tests show that children really
like this orange-colored preparation.

No mixing required. *Pediatric ERYTHROCIN Suspension*
is ready for instant use. Tested for stability at
extreme temperatures, the drug will remain potent
for at least 18 months.

Like ERYTHROCIN tablets, *Pediatric ERYTHROCIN Suspension* is specific in
action—less likely to alter the normal intestinal flora than other oral antibiotics,
except penicillin. Gastrointestinal disturbances are less common, with no
serious side effects reported.

Pediatric ERYTHROCIN Suspension is indicated in
pharyngitis, scarlet fever, pneumonia, erysipelas,
pyoderma, certain cases of osteomyelitis and other
infectious conditions. Especially indicated in
staphylococcal infections—because of the high incidence
of staphylococcal resistance to penicillin and other antibiotics.

Recommended dosage is 2 to 3 mg./lb. (4.5 to 6.5 mg./Kg.) at four to six-hour
intervals. Thus, one teaspoonful every four to six hours for a 50-pound child.
Can be administered before, after or with meals. *Pediatric ERYTHROCIN Stearate*
Oral Suspension, representing 100 mg. of ERYTHROCIN per 5-cc.
teaspoonful, is supplied in 2-fluidounce, pour-lip bottles.

Abbott

ALSO NEW: ERYTHROCIN OINTMENT, 1%, IN 1-OZ. TUBES



**Pours Everything-
With
Never a Drip
the New 1-Quart
**POLAR
WARE**
Beverage Server
of heavy gauge stainless steel**

There's a magic lip on this new pouring pitcher by Polar Ware. It won't drip — no matter what you pour, or from what angle you pour it. That means a glad good-bye to messy serving, an end to mopping up dribbles. And additionally, time gained in the faster filling of cups and glasses means time saved for other work.

A hinged cover is available if you'd like to make this all-purpose beverage server even more practical. It helps to "hold" hot coffee and iced tea; is

almost essential if you want to use the pitcher for ice box storage. Polar Ware seamless one-piece construction and heavy gauge stainless steel provide the enduring qualities you want for years of service.

Ask the men who call on you, or write direct for full information about this pitcher.

* To simplify reordering, you'll find the catalog number die-stamped on every utensil that Polar Ware makes. New York and Los Angeles warehouses are maintained for the convenience of suppliers.



Polar Ware Co.

Merchandise Mart—Chicago 54
Room 1100-1101

*415 Lexington Ave.
New York 17, N. Y.

*4300 LAKE SHORE ROAD
SHEBOYGAN, WISCONSIN

*123 S. Santa Fe Ave.
Los Angeles 12, Calif.

Offices in Other Principal Cities
*Designates office and warehouse

ONLY BOLTA LAMINATED TRAYS

give you complete

COLOR-and-PATTERN HARMONY of service and setting!



*Only BOLTA gives you such outstanding durability
in patterns and colors.*

- Non-porous, satin-smooth surfaces
- Impervious to cigarette burns, food acids, alcohol, fruit juices
- Lightweight, noiseless, easy to handle
- Washable in mechanical dishwashers
- Will not warp, split or stain
- 8x10, 10x14, 12x16, 14x18, 15x20



Also Famous Boltalite Hard Rubber Trays
in Sizes 12x16 and 14x18
Also Boltabilt Trays in Round, Oblong and
Oval Shapes in 15 Different Sizes

The vibrant, glowing colors of BOLTA LAMINATED TRAYS give zest to lagging invalid-appetites . . . and the lamination means extra long life — up to ten times longer life than you can find elsewhere because BOLTA — and only BOLTA — laminates seventeen (17) separate layers — fusing them by a special process to make BOLTA TRAYS more beautiful, more economical. BOLTA Laminated COLOR TRAYS outlast ordinary trays by 2-to-6 years. BOLTA TRAYS cost you less in the long run — much less.

The **BOLTA** Company
BOLTA CORPORATION OF AMERICA
LAWRENCE MASSACHUSETTS

Planning to Re-decorate? Specify BOLTAFLEX for booths and furniture, BOLTA-WALL for interiors

CUT COSTS NOW!

use **Dixie Cups'**
complete food service line!

- ✓ **Fast Service!**
- ✓ **Quiet!**
- ✓ **No Breakage!**
- ✓ **No Washing!**
- ✓ **Clean Service!**
- ✓ **Lighter Trays!**
- ✓ **Less Labor Costs!**
- ✓ **Stops Food Waste!**
- ✓ **Many Shapes & Sizes!**

Dixie Cup offers a better paper container for every need . . .



DIXIE FOOD DISHES
for salads, puddings, fruit, and dessert.



DIXIE COLD DRINK CUP
SAMPLING DIXIES
for water, fruit and vegetable juices, milk and soft drinks.

DIXIE HOT DRINK CUP
in a variety of sizes for coffee, tea, cocoa.



PAC-KUP FOOD CONTAINERS

for soups, stews and main dishes.
You can bake and serve in same Pac-Kup!

Dixie Cups...the paper cup everybody knows by name!



Dixie is a registered trade mark
of the Dixie Cup Company

DIXIE CUP COMPANY

EASTON, PA., CHICAGO, ILL., DARLINGTON, S. C., FT. SMITH, ARK., ANAHEIM, CALIF., BRAMPTON, ONT., CANADA



"Just what the Doctor Ordered..."

Pardon us if we use this catch phrase and appropriate picture to get your attention. We have no intention, at the moment, of speaking with the voice of medical authority about the food and nutritional value of turkey for hospital patients, though there are plenty of doctors and dietitians who will agree that delicious, tender turkey ideally meets the protein requirements for most hospital diets.

Aside from its suitability in hospital diets, our caption suggests a less obvious but equally valid second meaning:

TURKEY is a popular hospital dish!

It's a favorite with hospital patients; it is also easy and economical to serve . . . "just what the doctor ordered" for hospital chefs who are trying to make ends meet without shortchanging the patient.

The convincing story of turkey usage in hospitals is found in the new *Turkey Handbook*. Get your free copy by writing on your hospital stationery or by returning the coupon below.

NATIONAL TURKEY FEDERATION
Mount Morris, Illinois

FREE TURKEY HAND BOOK

NATIONAL TURKEY FEDERATION
Mount Morris, Illinois

Single copies of the "Turkey Handbook" free, additional copies available at 50¢ each. Send for your copy on your business stationery if you are engaged in quantity cookery.

Name of Institution _____

Address _____

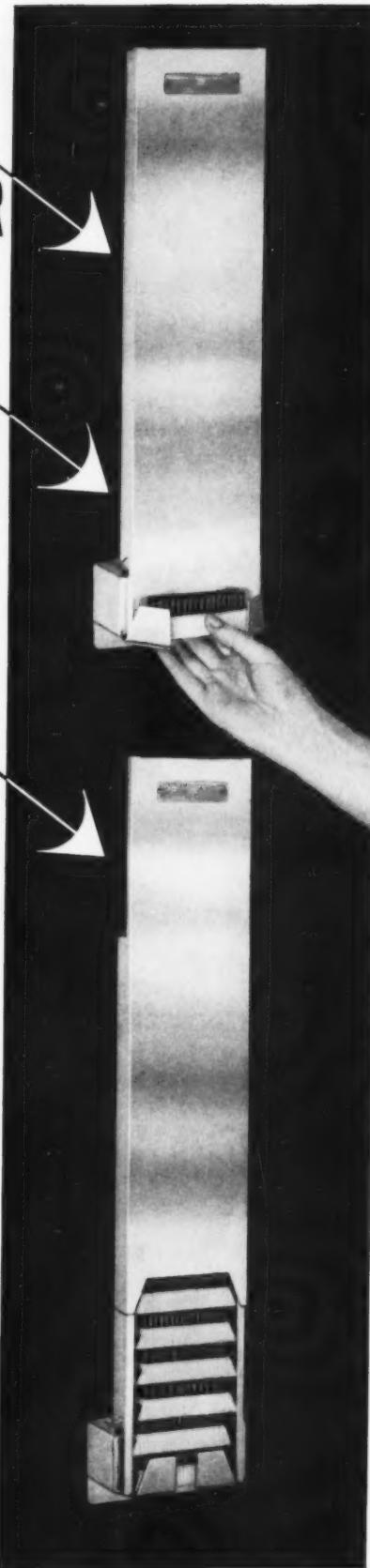
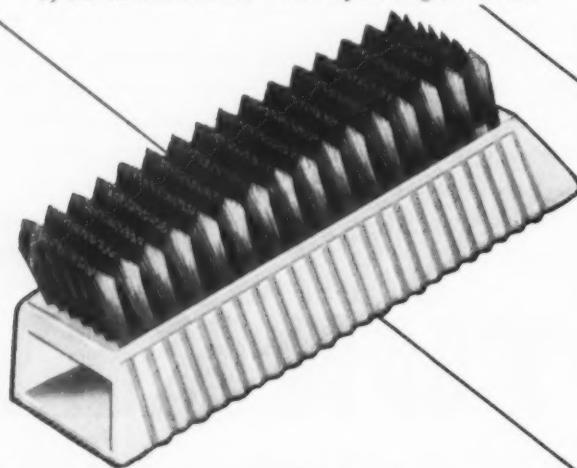
City and State _____

By _____ Title _____

NEW... WITHOUT COST

ANCHOR SURGEON'S BRUSH DISPENSER

By the Manufacturers of Anchor Nylon Surgeon's Brush



SPECIAL OFFER TO HOSPITALS

- 1 With each order of 6 dozen Anchor brushes, 1 brush dispenser will be supplied without charge.
- 2 With each order of 12 dozen Anchor brushes, 2 brush dispensers and wall bracket will be supplied without charge.

SPECIAL FEATURES OF THE ANCHOR SURGEON'S BRUSH DISPENSER

- Attractive compact design, stainless steel, lifetime construction with only 2 moving parts.
- Holds as many as 15 sterilized brushes.
- Specially designed vents permit circulation of steam throughout sterilizing process.
- Dispenser can be sterilized in 24 inch autoclave.
- Mounting attachment fits many existing wall brackets.
- Fits close to wall—projection only about 4 inches.
- Removable sliding cover permits easy filling and cleaning.
- Easier, faster, safer dispensing—a sterilized brush at the flick of a finger.

Offer available for limited time only. Cost of dispenser without brush order is \$27.00, plus \$6.30 for the wall bracket. Contact your dealer for further information.



Sold Only Through Selected Hospital Supply Firms

ANCHOR BRUSH COMPANY
AURORA, ILLINOIS

Write for Complete Information to Exclusive Sales Agent

THE BARNES COMPANY
1414-A Merchandise Mart • Chicago 54, Illinois



Dispensa-cart

**Reduces medicine dispensing
to simple routine**

**One trip service
by one nurse**

**30 oral medications
20 hypodermics**

**Safe, card-in-slot
identification**



... a truly sensational contribution to nursing efficiency

The new Aloe Dispensa-cart makes possible a definite, yet flexible, medicine dispensing routine that eliminates objections commonly noted in the usual medicine cart. An oral medicine rack mounted on the top has a capacity of 30 medicine glasses or paper cups, yet there is generous work surface remaining. Two removable hypodermic syringe trays hold 20 syringes in individual clips completely free from contact. Attached to posts of the frame are three receptacles mounted to swing out as needed: a stainless steel tray for discarded syringes, stainless steel cotton reservoir, and waste receptacle, interchangeable to suit your technic. A convenient shelf provides ample space for water pitcher and extra supplies.

Thus, after complete preliminary preparation of medication, with every dose identified by a card imprinted with name, room, medication, dosage and time, the nurse is ready to accomplish work in a single round that would ordinarily occupy the time of several nurses for a much longer period.

The Dispensa-cart has many incidental conveniences that speed up the nurses' work: flashlight, to provide light for quiet, bedside use; recessed ball-bearing swivel casters permit normal stride, pushing or pulling; full width handles with rubber bumpers. When you install this efficient system, you'll be amazed at the saving in nurses' time alone.

COMPLETE INFORMATION ON REQUEST

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Los Angeles 15 • San Francisco 5 • New Orleans 12 • Minneapolis 4
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A. S. Aloe Company

Send your illustrated folder with complete description and specifications of Aloe Dispensa-cart.

Name _____

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Robert M. Green & Sons, Inc.

FOUNDED 1874

Introduces a Complete Line of Hospital Equipment



This new factory of Robert M. Green & Sons, Inc., has just been completed. It is located at Nesquehoning, Pa. There are more than 75,000 square feet of floor area and it is equipped with the most modern high-speed production facilities which make possible a radical cut in delivery time.



Long life and ease of cleaning are built into every piece of Greenline equipment. Rigid, one-piece construction is achieved by using heavy gauge stainless steel with seamless welds that are highly polished. When color is desired, high-grade carbon steel is enameled.



SEE THE GREENLINE EXHIBIT, BOOTH 300, A.H.A. CONVENTION—SAN FRANCISCO

You will find many labor-saving features in this new Greenline of hospital equipment. It has been designed with the aid of leading hospital consultants, administrators, physicians and technicians.

This old company has had 78 years of experience in the fabrication of similar equipment. Two years ago it entered the hospital field. Now with a new plant and the latest production facilities, it is ready to provide you with hospital equipment under its trade-marked name—The Greenline.

FINEST QUALITY—LOW PRICE FASTER SERVICE

Each piece in The Greenline is designed to save steps or effort of the user and reduce clean-up time. Long-life is built in by its rugged construction and careful workmanship.

Yet the prices of The Greenline equipment will be no higher than competitive items. And you can obtain delivery in a few weeks instead of waiting several months.

GREENLINE EQUIPMENT AVAILABLE FROM DISTRIBUTORS

Distributors throughout the country are being appointed to handle The Greenline Hospital Equipment. One in your area will serve you as our agent.

Send today for The Greenline catalog. It will give you complete information and specifications for each item in The Greenline.

In the design of special equipment, the engineering staff of Robert M. Green & Sons, Inc., are glad to offer their services. You can be assured by their help of obtaining the finest possible equipment, embodying your ideas and meeting your specific needs and problems.

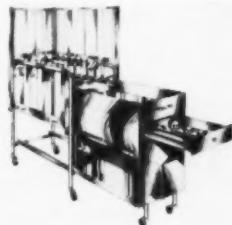
THE GREENLINE



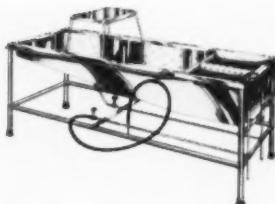
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The design of this Mobile Commode is radically new. It answers the need for a method of inducing bowel movement and micturition without discomfort. Any position for any patient is possible with adjustable foot rest, leg rest and back rest plus a seat that may be raised in the front to give the proper tilt.



Much nursing time will be saved by this Greenline combined Bassinet and Dressing Table. Unbreakable glass panels on three sides safeguard against air-borne cross infection.



Pathologists will appreciate the convenience of this Greenline Autopsy Table with its sliding instrument tray and other advantages. The sloping tank is covered with a film of constantly running water.



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SEND NOW FOR YOUR CATALOG

There are 230 pages with illustrations and specifications of equipment now in The Greenline. For your convenience the catalog is separated into tabbed sections as follows:

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Hampers, Trucks
Autopsy
Physiotherapy
Wheeled Equipment
Examining
Operating
Caserow and Lab.
Nursery
Room Furniture
Food Conveyors
Soda Fountain
Index
Prices*

**Robert M. Green & Sons, Inc.
Nesquehoning, Pa.**

Please see that I receive a copy of your catalog showing the new Greenline Hospital Equipment.

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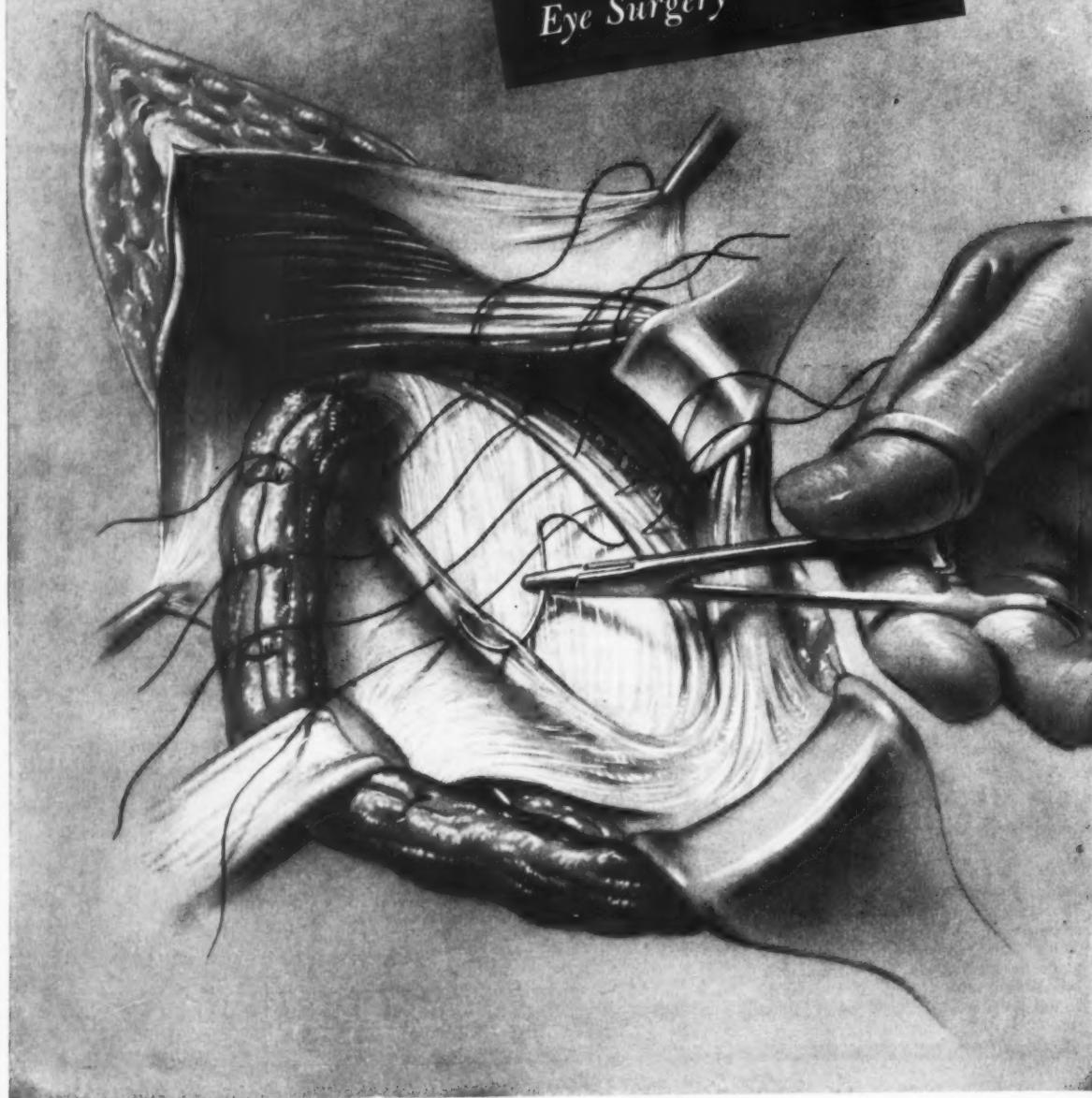
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Hospital _____

City & State _____

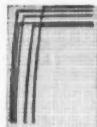
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Thyroidectomy
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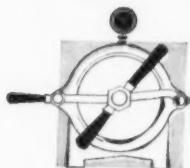


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5 ways better than ever before



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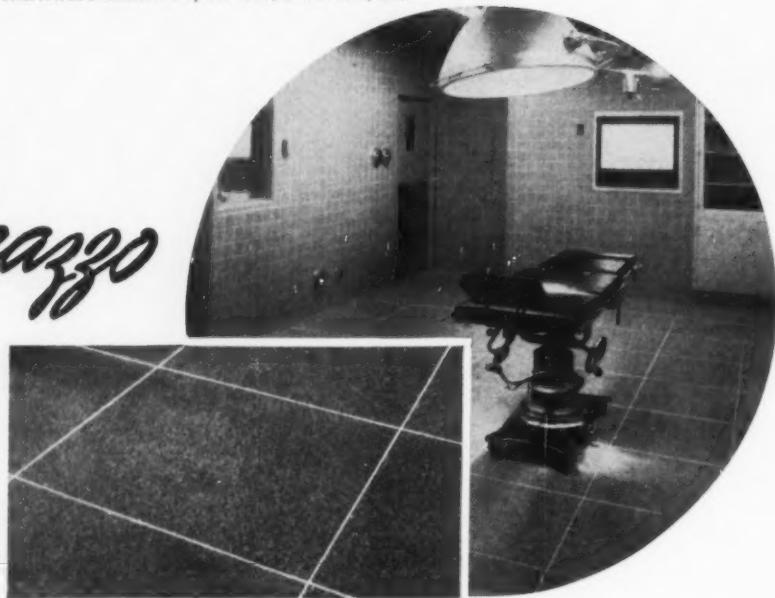
DAVIS & GECK, INC.



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provides
safety,
permanence,
cleanliness, and
easy maintenance



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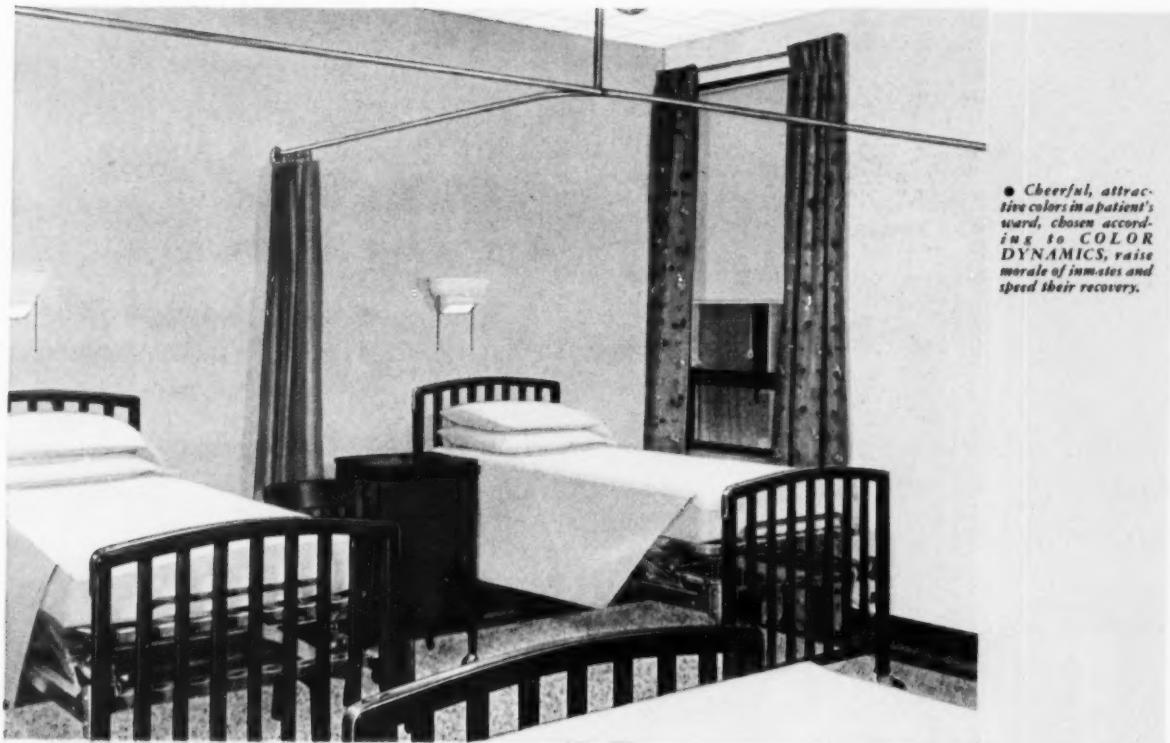
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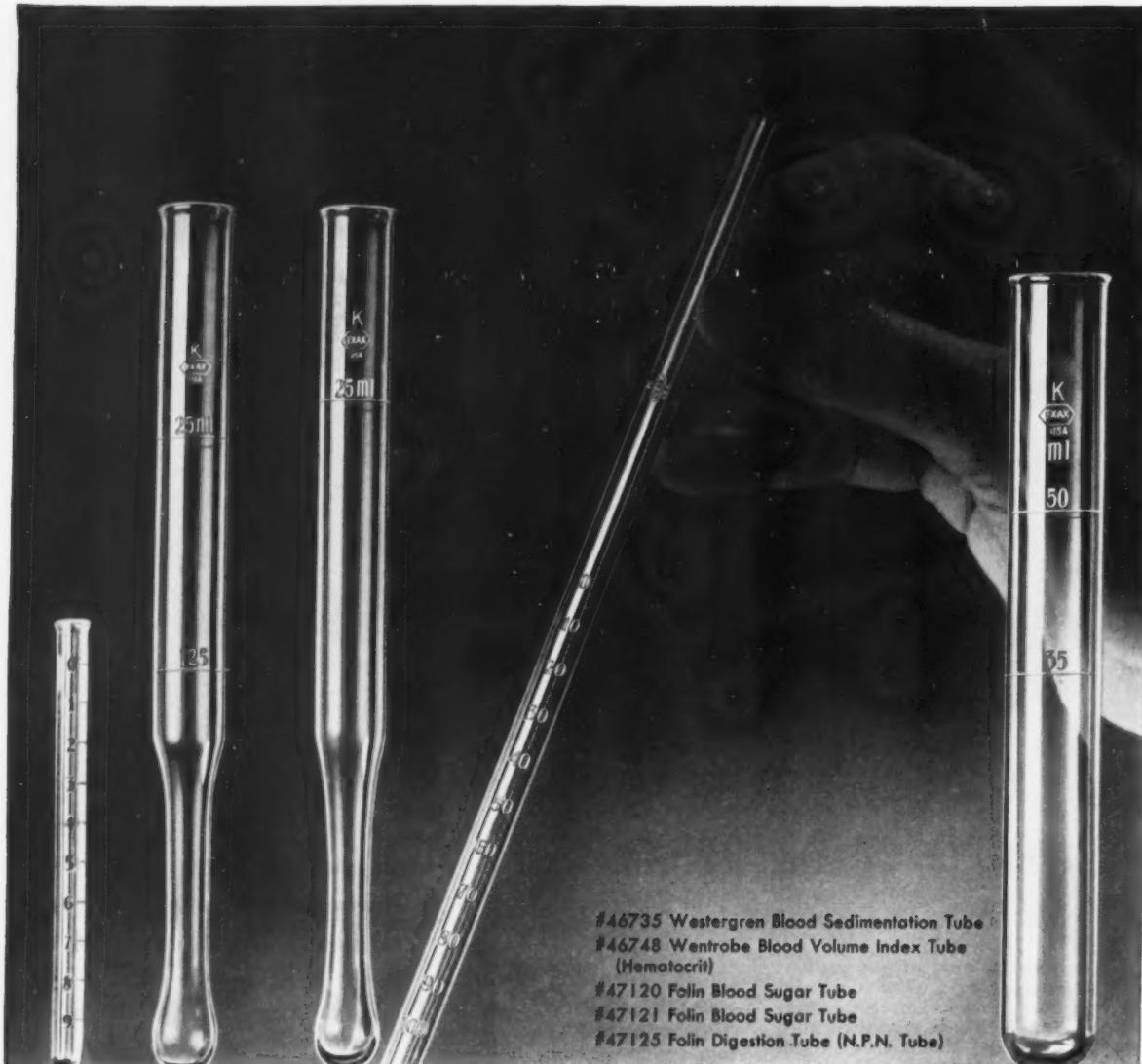
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vital in interpretation of sedimentation and volume index test results, Kimble Glass Company pays unusual attention to the selection of tubing for these tubes.

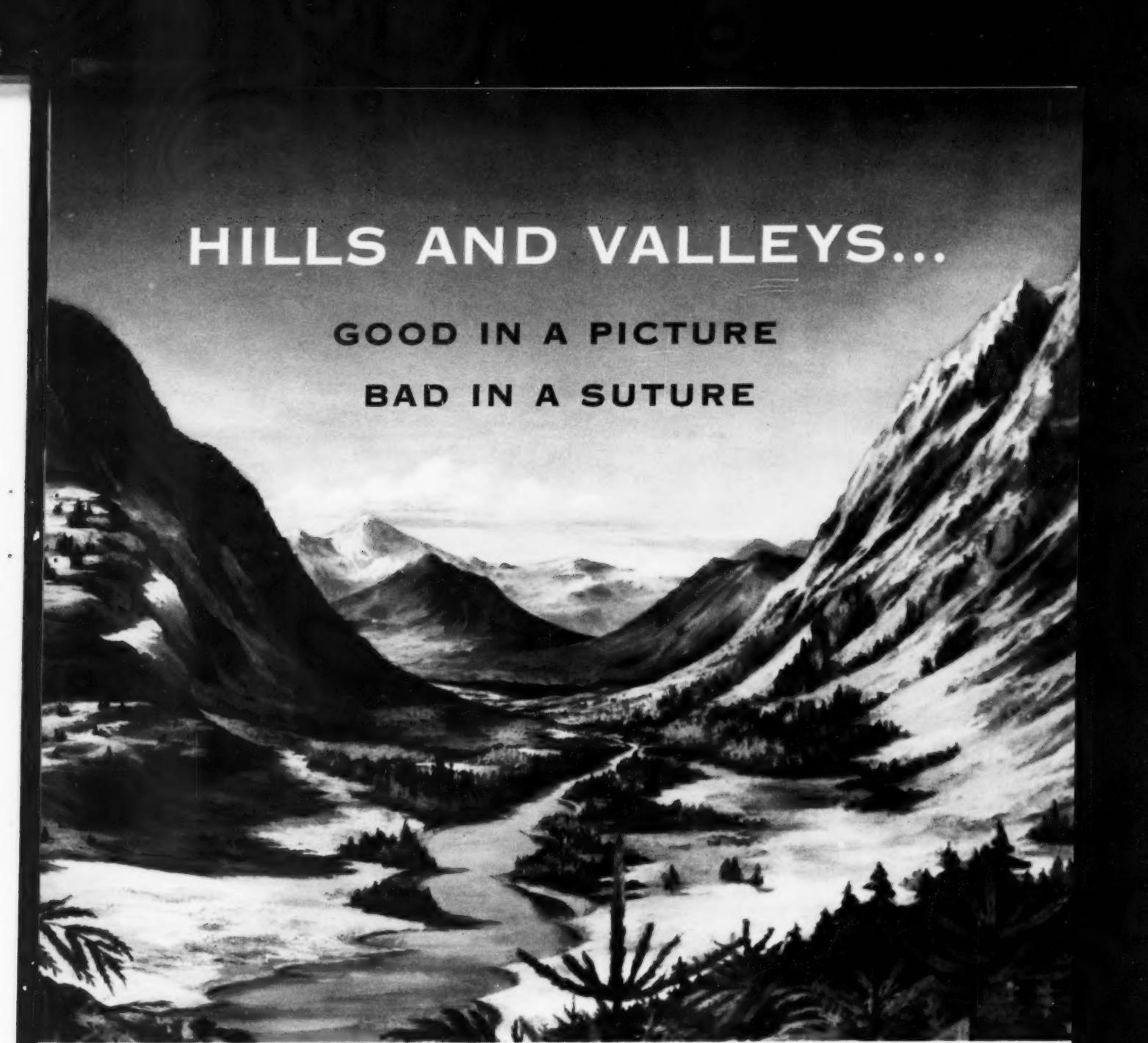
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A SOURCE of INCOME

*that is considerable and continuous
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 We would like to talk to your representative.

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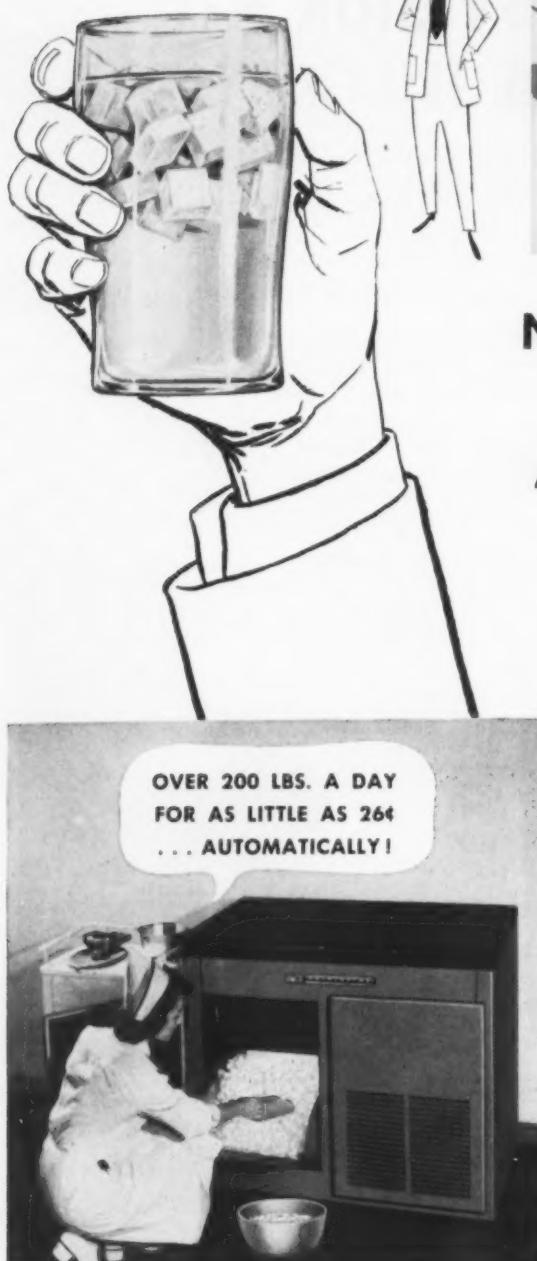
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NOW! Ice in a New, Handier Form with Frigidaire Automatic "Cubelet" Maker!

These tiny gems of pure, crystal clear ice cubelets are frozen under sanitary conditions — never handled until ready for use. $\frac{5}{8}$ " square, thick or thin as you prefer — they don't pack or lump together. Ideal for patients' water carafes, cool drinks, iced food service, ice packs, etc.

Decentralize your ice supply and save with Frigidaire Ice Cubelet and Cube Makers. Spotting them at various locations in the hospital eliminates mess, waste and labor of carrying ice from central location . . . more sanitary in every way. Completely automatic — all you ever do is open the bin and scoop out the ice you need. Quiet, dependable . . . powered by Meter-Miser warranted for 5 years. Find your Frigidaire Dealer in the Yellow Pages of your phone book. Or write Frigidaire, Dayton 1, Ohio. In Canada, Toronto 13, Ontario.

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RITZ CRACKERS

in individual
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only 1¢
PER SERVING

Everybody loves RITZ... America's favorite cracker...

**It's smart to serve RITZ regularly...with orders of
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- Each package contains two Ritz Crackers . . . just right for individual servings.
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LATE FINDINGS on the value of CITRUS

Where?	Why?	How?	References
in ABORTION	to help mitigate formation of hematomas in Rh-negative mothers; and in toxemias	citrus fruits and their concentrates and vitamin C supplement	Surg., Gynec. & Obst. 94:257, 1952
in ALCOHOLISM	to force fluids; and help assure adequate nutrition	vitamin C orally in large doses after acute stage has been brought under control	Virginia M. Month. 79:70, 1952
in AVIATION MEDICINE	to replenish vitamin C lost in hypoxemia or hyper-ventilation; and provide quick energy	liberal quantities of fruit or fruit juices	J. Aviation Med. 21:283, 1950; Mil. Surg. 108:125, 1951
in BURNS	to improve nutrition prior to grafting; and promote healing	large doses of vitamin C as soon as patient can eat	Am. J. Surg. 83:746, 1952; GP 5:35, 1952
in OBESITY	to appease appetite during reducing; and combat hypoglycemia	50 calories of citrus fruit (e.g. 4 oz. fresh orange juice) before lunch and dinner	Postgrad. Med. 9:106, 1951
in PEPTIC ULCER	to avoid vitamin C deficiency; aid healing and assist in weight control	2-3 oz. strained citrus fruit juice in water (or milk) at end of meal	Sandweiss: "Peptic Ulcer," 1951; "Low Cost Therapeutic Diets," 1952
in RHEUMATIC CONDITIONS	to maintain good nutrition without obesity; provide purine-free food; and help reduce inflammation	for arthritis, high-vitamin diet; for rheumatic fever, orange juice 200 mg. daily; for gout, diet prominent in fruits, including citrus	Am. Pract. 2:577, 1951; "Current Therapy," 1952

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FLORIDA Citrus

ORANGES • GRAPEFRUIT • TANGERINES





Architects-Engineers: Fine and Miltenberger, N. Y., N. Y.

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The surgical areas of Valley Hospital, Ridgewood, New Jersey, now have a completely reliable flooring safeguard against devastating anesthetic blasts: Gold Seal Nairn Static-Conductive Linoleum . . . the only linoleum in the world with the remarkable property of dissipating static electricity which might otherwise present an explosion hazard.

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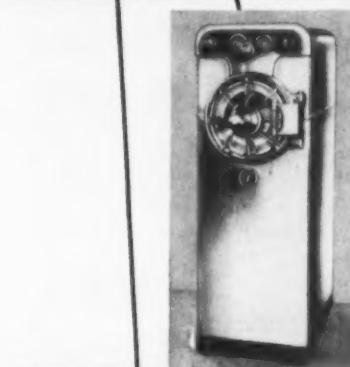
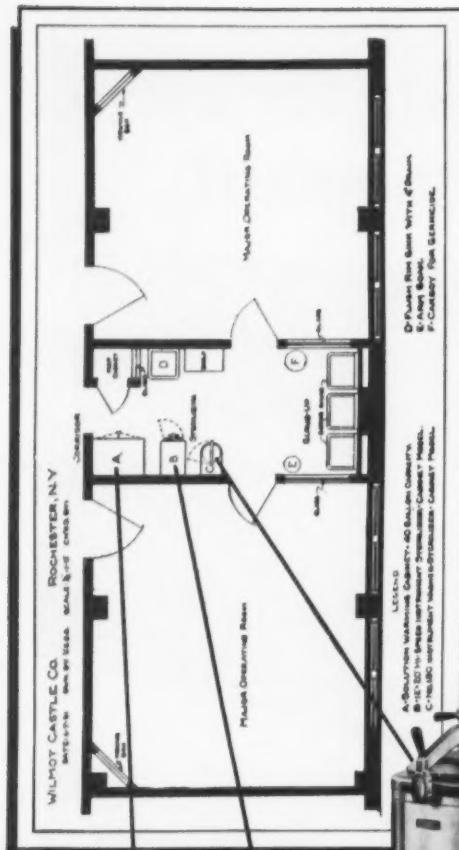
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Precision built for temperature control of flasked sterile water, parenteral solutions, blankets and other supplies normally sterilized in the Central Sterile Supply.

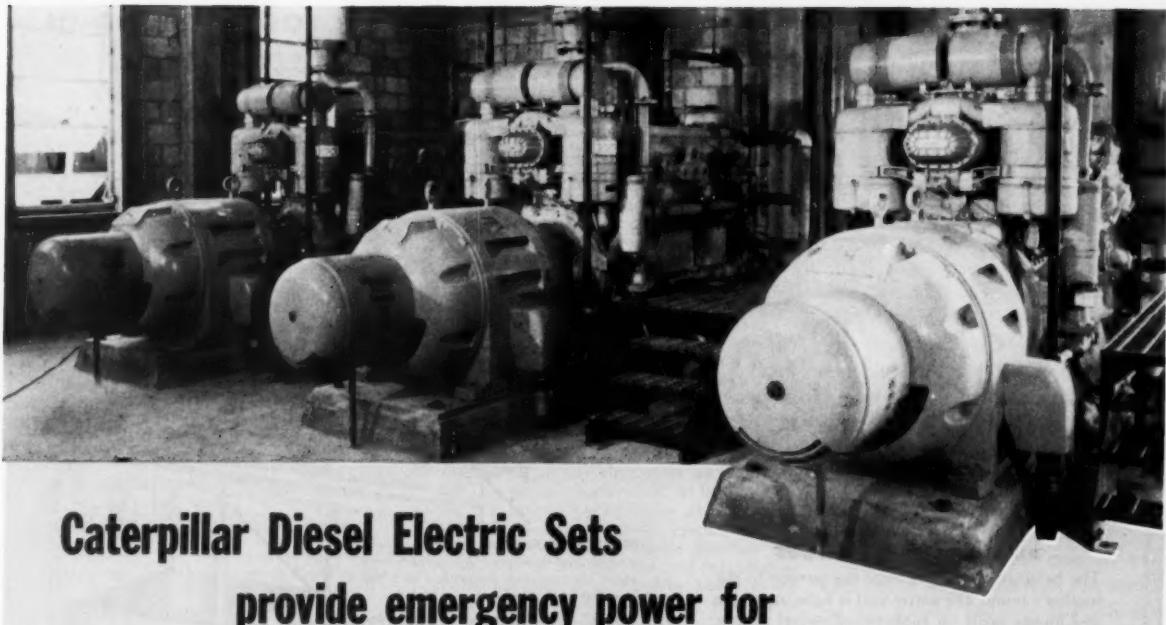
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THE MODERN HOSPITAL



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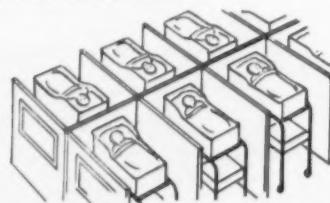
New 2-Way BASSINET

1. FOR ROOMING-IN TECHNIQUE
or
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The bassinet is wheeled from the nursery to the mother's room. The entire unit is light in weight and moves easily on rubber-tired swivel casters. Extra-long extension base slides under bed, brings basket and supplies within easy reach for mother to work on infant.



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Small Hospital Questions

Same Standards for All

Question: Will standards followed by the new Joint Commission on Accreditation of Hospitals be different for small hospitals than for large ones?—B. A. D., Ind.

ANSWER: In discussing this question, Dr. Edwin Crosby has stated that the standards will be exactly the same for hospitals of all sizes. Certainly, there can be no lower standard for medical and hospital care of patients in small hospitals than those followed in the larger institutions.

Indirect Hospital Costs

Question: Is there an acceptable and known guide for figuring indirect costs of hospitals?—M. R., Mo.

ANSWER: In order to get at this problem and to develop some uniformity in accounting among all hospitals in the country, it is important that the standard direct charts of accounts developed by the committee on accounting of the American Hospital Association be used in all hospitals. There are three accepted methods for spreading the costs of the nonrevenue-producing departments over the revenue-producing departments so as to arrive at a true cost for these revenue-producing departments on which to base charges. The American Hospital Association's committee on accounting will, in the near future, be publishing the second volume of its manual on accounting. This second volume will completely explain the various methods of arriving at true costs in the revenue-producing departments.

Best Use of Call Systems

Question: What must be done to get maximum use of patient-nurse communication call systems?—L. F. D., Calif.

ANSWER: It is important to have head nurses, supervisors and nursing personnel thoroughly familiar with these systems before they are installed. Care must be taken to educate all of these people in the proper use of these patient-nurse communication systems. In addition to this, probably the most important thing is to be certain that there is a nursing unit clerk stationed at the nursing station desk at all times to receive calls from patients over the communication system. Unless there is somebody on hand at all times to get the call from the patient and to ar-

range for dispatching of the proper person to answer the call, no system can be used to its full effectiveness.

Stand-By Boiler Needed

Question: Our 56 bed hospital recently installed a new, oil-burning, high-pressure, compact marine boiler. The second boiler is now 20 years old, is hopper fed, coal burning and has shown signs of pitting. I would like your opinion as to the usual policy pertaining to boiler equipment for a hospital of our size. Is it necessary to have a second boiler and is it necessary for the second boiler to be able to carry the full load of hospital requirements throughout the year? Some question has arisen as to whether the old coal-burner could be used as a stand-by boiler to be used in emergencies until such time as it is actually condemned.—J.S.E., Ohio.

ANSWER: I assume that your new oil-burning, high-pressure marine boiler has sufficient boiler horsepower and steam output capacity to handle your entire load. It is generally considered good practice to have a stand-by boiler capable of carrying the whole load of the hospital, even though it has to be pushed up above its normal rating. No hospital can ever afford to take the chance of not having steam. It is for this reason that architects, consultants and other students of hospital problems urge that there always be a stand-by boiler capable of carrying the whole load.

I assume that your second boiler, which is hopper fed—and by that I presume you mean stoker-fired to handle coal—also has the capacity to carry

your load. If your insurance boiler inspectors go over this old boiler and determine what must be done to put it in reasonably good operating shape, you could then get estimates on the cost of this repair work. If it seemed practical, this old boiler could be kept for stand-by purposes.—E. W. J.

Production of Records Legal

Question: Is the hospital obliged to furnish records to the Commissioner of Internal Revenue for investigations of an individual doctor's income tax payments?—R.F.S., Ill.

ANSWER: A recent case in which this point was decided by the court is in re *Albert Lindley Lee Memorial Hospital*, decided in the U.S. District Court for the Northern District of New York on Feb. 25, 1953.

In November 1952 the Commissioner of Internal Revenue issued a summons to the hospital requiring the production of books, papers and records in regard to the matter of the tax liability of Dr. Anthony J. Cincotta. The summons specifically required the records of "the names and addresses of Dr. Cincotta's patients admitted to the hospital on his instructions during the years 1946 to 1950, inclusive." The administrator of the hospital appeared in court and expressed his uncertainty as to whether voluntary production of the information desired would be in violation of Sec. 352 of the New York Civil Practice Act, pertaining to privileged and confidential communications between a doctor and his patient.

After reviewing the cases on the matter, the court stated that it did not see how a person could be injured by the disclosure of the fact that he had received the services and care of a hospital and had been attended by a certain physician. Accordingly, the court authorized the inspection of the hospital records for the purpose of ascertaining the names and addresses of the doctor's patients admitted during the years in question. The hospital, however, was directed to take all precautions necessary to ensure that the treatment afforded any patient or the diagnosis of his illness should not be disclosed by such examination.—ROBERT F. SPINDELL, attorney, Chicago

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THE MODERN HOSPITAL

AUGUST
1953



LOOKING AROUND

Requiem

WITH this issue, The MODERN HOSPITAL is 40 years old, an occasion that is saddened by the death a few days ago of our beloved president and publisher, Dr. Otho Fisher Ball, who founded this magazine in 1913 and has been its inspiration ever since. As a man does at 78, Dr. Ball liked to recall the past and evaluate current events in historical perspective. Thus he had spent many hours, these last few weeks, reviewing early issues of The MODERN HOSPITAL, discussing the developments in the hospital field with which the magazine was concerned in its first few months, and suggesting what were to have been the commemorative features of this anniversary issue. It was characteristic of Dr. Ball to view an occasion of this kind more as a promise for the years ahead than as a remembrance of years past. His concern was not to measure how far we have come, but to show which way we are going. He was interested in the past chiefly because it illuminated the future, and his vision of the future—as it is for all men of high purpose and great achievement—was Dr. Ball's lifelong fascination.

* * *

Dr. Ball's vision of the future was painted in bright colors in the first issue of The MODERN HOSPITAL, published in September 1913. "There is so much to be done," said an editorial in that magazine. "It is decreed that

there shall be a bed in a good hospital for every sick and hurt man, woman and child, and that every resource of medical skill, seconded by the highest order of trained nursing and aided by all the arts and sciences, shall be at the service of rich and poor for the cure of disease. But it is no longer enough that those who can shall merely help to cure disease; the time is come when the prevention of disease looms larger than the cure, and in this field the hospital must show the way.

"Even here the hospital finds no pause. Men were not born free and equal; the scales of justice have not weighed for all alike, and so it becomes the duty of the hospital, in its larger sense, to even the balances, and to bring to the lowly and oppressed the beneficences of Faith, Hope and Charity. These are the appointed works of the hospital of the future."

* * *

That was the vision, and for Dr. Ball vision was always a spur to action. The purpose of The MODERN HOSPITAL, as he saw it in those early days, was "To give hospital workers everywhere a bond of union, an agent for the collection and dissemination of experience and knowledge concerning their common service to humanity . . . a vehicle of expression that will bring into wider usefulness the experience and learning of each individual, to the end that these may become the common harvest of all."

As there are today, so there were at that time skeptics who doubted that a magazine could, for long, hold fast to this lofty purpose. "Someone asked not long since," Dr. Ball said in the issue of October 1913, "what The MODERN HOSPITAL would do for material when its writers had exhausted all the topics of hospital architecture, equipment and administration, which he presumed would take three or four months."

In reply, the editor lifted his vision to the far-off horizon of the hospital world—a horizon toward which we have been moving steadily for 40 years, one which is seen by many more people today than it was then, but which remains, for all that, in the still hazy distance. "The hospital is manifestly to take on new duties and far greater obligations than we have heretofore dared to think about," he said. ". . . If we begin to sum up the duties of the modern hospital and follow it through all its ramifications, we must go into every home in the land, and invade every stratum of society. Wherever there is a human being, there is a health problem; and wherever human health is concerned, there is a duty for the hospital. And yet one asks what is to be done about topics to be discussed?"

* * *

As it has been in recent years, The MODERN HOSPITAL in 1913 was concerned with the problem of hospital

inspection and standardization. One of Dr. Ball's associates in planning the magazine, and its first editor, Dr. John A. Hornsby of Chicago, addressed himself to the subject then in an article which was a notable example of how a magazine may bring into wider usefulness the experience and learning of each individual, to the end that these may become the common harvest of all. "The time would seem to be at hand," he said, "when hospitals should think about organization, standardization, classification—system. . . . But who is to set the standards? How shall standards be arrived at? What shall be their scope?"

Dr. Ball's answers to these and other problems were right answers for that time, and, unquestionably, his declaration of the truth as he saw it then had a great deal to do with the initiation, not long afterward, of a hospital inspection and standardization program—though he never received credit for his contribution to the movement, and never wanted credit. As the program has evolved down the years, *The MODERN HOSPITAL* has reported and interpreted events, and made new estimates of the truth. These later estimates have also made their mark on the times, contributing something to the development of hospital standardization, and something to the good life of a publisher with a steadfast purpose and a bright vision of the future.

* * *

"In some hospitals there exists jealousy of the staff by the superintendent, and jealousy of the superintendent by the staff," a *MODERN HOSPITAL* writer observed 40 years ago, giving public expression for the first time to a problem that remained one of Dr. Ball's major interests through all the years. "It has been the custom of hospital boards to create top-heavy staffs. There will be one member so dominant, and usually so domineering, that everything in the institution is warped in his interest. The strong one gets what he wants by the very force with which he goes after it, and all the other men can do is to protest and sulk. . . . The fault lies with the board of trustees for building a machine whose parts do not coordinate.

"Every staff should have an organ-

ization, with officers and committees, and these committees should go at the hospital problems with a view to mastering them. . . . If there be a recalcitrant—the strong man—let the board know definitely that the staff is unanimous, except the one. The board may decide with the strong one once, or even twice, but it will not require many meetings before even the most obtuse board finds out that there is a disturbing element, and will either straighten him out or let him out."

Jealousy between staff and administration is not unknown today, and the staff strong man still haunts the dreams of the conscientious administrator. But administrators and trustees have come a long way toward recognition of their responsibility for what the doctor does, and "straighten him out or let him out" is still a drastic measure, but no longer a shocking one. We have come a long way, too, along the road of staff organization that was foreseen by Dr. Ball 40 years ago, so that there are ever more effective methods of dealing with recalcitrants within the staff structure. The joint conference, the tissue committee, the medical audit—these and other measures have been reported consistently over the years in *The MODERN HOSPITAL*. There was no one more devoted than Dr. Ball was to the proposition that there shall be more and more who are straightened out, and fewer who are let out.

* * *

Contemplating this magazine's responsibility to report the forthcoming San Francisco convention of the American Hospital Association, Dr. Ball turned to the issue of October 1913 and its report of that year's A.H.A. meeting, at Boston. "Boston provided the best working program the association has probably ever had," this began. "There were a great number of extremely important papers . . . tending to show the drift of thought among hospital people.

"The meeting ran smoothly from start to finish," the account continued, "with just enough piquancy furnished by Rev. Dr. Kavanagh and Dr. Fowler, of Louisville, to keep up the interest."

The piquancy had developed, it turned out, when Rev. Kavanagh pro-

posed a change in the association's constitution to eliminate the nominating committee, which he thought was undemocratic, and when Dr. Fowler, obviously a contentious character, sounded off on the subject of nurse anesthetists, whom he disliked, and charity patients, many of whom he thought could pay their own hospital bills, if the truth were known.

There were 400 people at the Boston meeting, the report said. Looking forward to San Francisco and its thousands this year, Dr. Ball had the same objectives in mind that he had in Boston 40 years ago—to show the drift of thought among hospital people, including any notable piquancies, and to help, in all the ways a magazine can help, to ensure that the convention would make the experience and learning of each individual the common harvest of all.

* * *

A man's body is undeniably old at 78. He may still work and golf and fish, as Dr. Ball did until he died, but the eyesight dims, the muscles tire, the heart labors and, when God wills it, stops. A man's body is old at 78, but a man's mind and spirit may still be young, if he has had a good life and kept a bright vision of the future. Like a man at 78, a magazine at 40 may be old in years but young in mind and spirit, if it has had a good life, and if it has a bright vision of the future. For a magazine, as for man, the good life must have some prosperity and some adversity, some adventure and some meditation, a measure of recognition and a measure of criticism, useful work, great friends, and, above all, a steadfast purpose that gives meaning and direction to daily existence.

Because he had a good life and a bright vision, Otho Ball stayed young as few men are privileged to do. Because of the life and vision he gave it, *The MODERN HOSPITAL*, like its founder, has stayed young while it was growing old. A man dies, but a magazine with a heritage of useful work, great friends and steadfast purpose may live on. The condition of renewed youth is a bright vision of the future. This too is our inheritance from Dr. Ball, and this we shall treasure as we do his memory.

They Made Hospital History

Otho Fisher Ball, M.D.

June 20, 1875—July 19, 1953

A FEW DAYS before he died, Dr. Otho Fisher Ball, founder and publisher of *The MODERN HOSPITAL* magazine and president of The Modern Hospital Publishing Co., was discussing a forthcoming publishing venture with an associate. In his hands Dr. Ball had a memorandum from a consultant who had reviewed the project and, while giving it cautious approval, suggested certain limitations in its dimensions. Dr. Ball was disappointed in the consultant. "He doesn't see the big picture," he said, tapping the memorandum. He went on to outline the picture as he saw it. As he always did, Dr. Ball saw it big.

A man who was usually content to let others write and speak for him, Dr. Ball was always more concerned with generating a big idea and delivering it safely into the hands of those who would carry it through than he was in establishing or maintaining his own identity with it. Unquestionably, it was his interest in big ideas, and his unconcern for personal credit, that enabled Dr. Ball, at 78, to make plans for the future with an energy and enthusiasm which frequently astonished, and often exhausted, men who were half his age—including some who pride themselves on their vision. Within the past two or three years, for example, he considered and rejected at least two plans for launching new magazines, not because he was fearful of embarking on new ventures at his age but because the projects involved seemed to him to be limited in scope. He couldn't see them big, and so he wasn't interested.

In contrast, Dr. Ball had a big concept of the hospitals, schools and colleges served by the magazines his company published. On one of the rare occasions when he spoke for himself in the hospital field, in an article published in 1935, he stated his vision of the hospital of tomorrow in its most succinct terms. "Hospitals should cease to be walled towns," he said. It was this concept which prompted him to organize *The MODERN HOSPITAL* 40 years ago, and it was this concept which made him, over the years, one of the most consistent advocates of the hospital which understands and takes its place in society, alongside the church, the home, and the school, as an institution with far-reaching social responsibilities. In Dr. Ball's view, greatness in a hospital was never a product of size. "A hospital may be a distinguished institution, no matter what its size," he said years ago, "if it is great in spirit, original in its outlook, creative in its service and inspiring in its community relationships." Those are exacting standards, but there are no better ones by which the performance of a hospital could be judged, at that time or today.

The son of a doctor in Waterloo, Iowa, where he was born on June 20, 1875, Dr. Ball was reared in a medical atmosphere at a time when hospitals were rarely distinguished, creative or inspiring. As a young doctor in St. Louis following his graduation from medical school there in 1897 and, later, as publisher of the *Interstate Medical Journal*, Dr. Ball and his early medical associates had become concerned about

the walled-town concept of the hospital that prevailed at the time. A St. Louis philanthropist, George D. Barnard, came to Dr. Ball when he decided to give money to provide a modern plant for the St. Louis Free Skin and Cancer Hospital, which was overloaded and inadequate. In the study which he undertook for Barnard, who wanted the best information available on hospital planning and equipment, Dr. Ball visited hospitals throughout the United States and abroad. In the course of developing plans which resulted in the present Barnard Free Skin and Cancer Hospital, Dr. Ball discovered a total lack of organized data on hospital construction, equipment and administration.

While he was brooding about the sad state of hospital affairs his studies had uncovered, Dr. Ball's attention was drawn to a speech made by the mayor of St. Louis. In the traditional manner of mayors the world over, His Honor had laid claim to the most efficient city administration since the Age of Pericles. Among other things, he boasted, "The St. Louis City Hospital has the lowest per capita cost and the lowest food cost of any similar institution in the country." As it happened, and as Dr. Ball well knew, City Hospital at that time also had the poorest quality of service, bed for bed, of similar institutions anywhere, but this was a point, apparently, that had escaped the mayor's interest. At about that time, too, Dr. Ball's son became critically ill, and, during months of daily hospital visits, he came to understand that even the best hospitals badly needed better



administrative methods. In a mind that was actively concerned about hospital problems and the absence of orderly information on hospitals, these were the sparks that ignited the big idea—for a hospital magazine that would fill the obvious need, comprehending the quality of service to patients as well as the cost of a meal.

As the big idea emerged in the shape of publication plans, Dr. Ball enlisted the help, and the enthusiasm, of his many friends in the hospital field. Dr. S. S. Goldwater, then superintendent of New York's Mount Sinai Hospital, became the magazine's "godfather," contributing as much to its underlying philosophy in the prenatal months as he contributed later, for many years, to its contents. Dr. John A. Hornsby, superintendent of Michael Reese Hospital, Chicago, and a man with newspaper experience, became the magazine's first editor. Dr. George H. Simmons, editor and secretary of the American Medical Association, was persuaded to organize a hospital section of the A.M.A., and a report of the first meeting of this section became a feature in the first issue of *The MODERN HOSPITAL*, published in September 1913.

It couldn't have happened at a better time. The practice of medicine in hospitals was in a period of ferment, and those same prewar years saw the emergence of new concepts in medical and hospital economics. New anesthesia methods were being introduced, using mixtures of ether and other gases; the first electrocardiograph had just been developed; intravenous therapy was discovered; the American College of Surgeons was established; hospital outpatient departments were an innovation; the "hospital year" was being advocated as a requisite for medical licensure; a few universities were introducing courses in nursing education. In all these and many other events and movements of the time, *The MODERN HOSPITAL* took a lively interest—investigating, reporting, evaluating, as it has done for 40 years, and as a magazine must do if it is to serve its readers as a true organ of the free press in a democratic society, and not simply as a compilation of printed information, like a telephone directory.

Occasionally in those days, as it has happened since, Dr. Ball's friends in the hospital field took him to task for presenting both sides of an issue on which the objectors had either strong opinions or closed minds, or both.

Invariably, Dr. Ball was at pains on such occasions to explain the magazine's position. "The proposal was news and continued to be a subject of journalistic interest," he wrote to one hospital authority who complained about the report of a contentious project which had appeared in *The MODERN HOSPITAL*. "It may not be apparent to all readers that on many matters of a controversial nature the function of our magazine is to serve as an open forum, especially on subjects where there are opposed viewpoints in our own field. The understanding exists among the editors and myself that our journalistic responsibility is to enlighten the whole field by presenting the most authoritative opinions on all aspects of current problems, rather than to assume that we know all the answers. Ours is a job, as I see it, of accurate reporting and judicial review, plus the obligation of exploring new ground, hand in hand with leaders in the profession of hospital administration."

When criticism came from men he respected, or from close friends, Dr. Ball would go to great lengths in his explanations. "Because of our lasting friendship and my high regard for any criticism coming from you, I have devoted Sunday to a careful review of the subject," he wrote a friend on one such occasion, concluding a long, detailed memorandum. "If I have not clarified the matter for you, please let me have the benefit of your comment as promptly as possible, because I am unwilling that there should be any misunderstanding with one of my oldest and best friends." Under different circumstances, he used different methods: "Your letters have been referred to our attorneys," he wrote tersely to a man who was threatening to sue the company for imagined damages. The man was never heard from again.

Whether the critic was a friend or a crackpot, however, Dr. Ball invariably backed up the editors, who had complete freedom in selecting the contents of the magazine. Especially in the early days, Dr. Ball would suggest topics for editorials and articles, but he never dictated treatment, as long as he was satisfied that his associates understood his concept of the journalist's responsibility for accurate reporting and judicial review, plus the obligation of exploring new ground, hand in hand with leaders in the profession.

Hand in hand with the hospital leaders of 1913, Dr. Ball and The

MODERN HOSPITAL explored the new ground of hospital standardization. They found it fertile and ready for cultivation. Through reading articles and editorials in *The MODERN HOSPITAL*, and through discussions with Dr. Ball and Dr. Hornsby, Dr. John G. Bowman, educational director of the newly organized American College of Surgeons, became interested in standardization, and, in 1917, the college program was inaugurated. "The hospitals of the United States are to be standardized," the magazine proclaimed in its report of the program's organization meeting in October 1917. "It looks now as though we were on the threshold of some very radical progress." One of Dr. Bowman's enthusiastic volunteer evangelists for the gospel of standardization in those early years was a young man who was superintendent of the Vancouver General Hospital at Vancouver, B.C. He had written extensively on the subject in early issues of *The MODERN HOSPITAL*, and, when Dr. Bowman left the college to become chancellor of the University of Pittsburgh in 1922, Dr. Ball suggested that the young man, a Dr. Malcolm T. MacEachern, might be a good choice as successor to the job. He was.

As a man in his position is likely to be, Dr. Ball was besieged with requests for recommendations—from boards seeking administrators, and from administrators seeking hospitals. Unhappily, his candidates were not always as able, or as successful, as Dr. MacEachern was. A man of big ideas himself, Dr. Ball sometimes became enraptured with lesser men who shared his big ideas but lacked his shrewd judgment and ability to make ideas work. In these cases, his recommendations backfired. When this happened he never took the view, as many men would, that the unsuccessful candidate had let him down. Instead, with undiminished faith, he kept trying to help—sometimes advancing funds, as well as encouragement, to bridge awkward periods between assignments. Some of these luckless protégés roamed the field for years seeking the square hole that would fit their peculiar talents, but in many cases, aided by Dr. Ball's advice and inspired by his confidence, they found themselves and justified his trust. Among all the satisfactions that come to a man whose big ideas ripen into effective action, nothing pleased him more than this.

Dr. Ball admired courage as much

as vision, and he loved men who had strong convictions and the moral courage to state their convictions unequivocally, even at the sacrifice of prestige and popularity. His love of a fighter, in fact, went beyond human beings and extended into Nature. On one occasion when he was fishing at a favorite lake in the Canadian wilds, he hooked a 5 pound bass that put up a terrific battle—running, jumping, and diving ferociously for nearly half an hour. With all the skill, energy and patience of a good fisherman, Dr. Ball played the bass until its strength gave out, finally bringing it to the surface alongside the boat. His partner came forward with the net, but Dr. Ball waved him away. Slipping his hand under the fish in the water, he gently removed the hook from its mouth and watched it slide back to the depths. "It put up such a gallant fight," he said to a friend later, telling about the incident, "that I couldn't bear to end its life."

As softhearted with friends as he was with fish, Dr. Ball loved companionship, though he hated crowds and never attended meetings if he could possibly avoid them. While he had withdrawn from active association with the hospital field in recent years, most of the great men of medicine and hospitals, from the early 1900's down to the present time, were among his close friends, and he liked nothing better than to sit late with them, smoking cigars, sipping a highball and talking into the night about men and affairs—in the hospital world and the world at large. His friendships in the hospital and medical industries, too, included most of the men who have been active in that field during the last 40 years, many of whom got their start when Dr. Ball first took an interest in what they were trying to do.

Because he enjoyed good food, comfortable surroundings and all the other trappings of pleasant living, and liked to share these comforts with his friends, some of his acquaintances in the hospital field had the idea that The Modern Hospital Publishing Co. was a gold mine. Actually, like businessmen throughout the country, Dr. Ball made money on stocks and real estate in the booming Twenties, and lost it in the gloomy Thirties. Unlike many businessmen, however, he was always more interested in ideas and men themselves than he was in their fiscal possibilities. Consistently over the years, for example, he turned down

advertising from manufacturers whose products or services he judged inadequate to serve the best interests of hospital patients. As publisher of the *Interstate Medical Journal*, which he organized with a group of young St. Louis doctors in 1903, he had taken vigorous steps to clean up medical advertising, which was then in a deplorable state that made it virtually impossible, from the copy, to distinguish ethical products from snake oil.

His wide knowledge of hospitals and the hospital industry made it inevitable that, during World War I, the Council of National Defense and officers of the army and navy should turn to Dr. Ball for information about hospital and medical supplies. With Dr. Hornsby he conferred endlessly with manufacturers and government officials, obtained buildings for military use, and produced a mass of information on all phases of hospital procurement. Out of all this information came a special War Issue of *The MODERN HOSPITAL* in August 1917. Out of it, too, grew an idea for a different kind of publication, and in 1919 the *Hospital Yearbook*, now the *Hospital Purchasing File*, was born. To be nearer the hub of war-time activity Dr. Ball had moved the company's headquarters to Chicago in 1918, soon afterward buying an old mansion at 22 East Ontario Street—the building that has since been occupied by L'Aiglon Restaurant. In the years following the war, 22 East Ontario became known as a national center of hospital information. In addition to *The MODERN HOSPITAL*, it housed the headquarters of the American Hospital Association, a Hospital Library and Service Bureau established by the Rockefeller Foundation, urged on by Dr. Ball, and the National Catholic Welfare Council.

During those years of shared accommodations, *The MODERN HOSPITAL* and the American Hospital Association worked closely together for the betterment of hospitals and the welfare and comfort of hospital patients. It was Dr. Ball who urged the association, as a means of advancing the education of administrators and, at the same time, improving its revenues, to establish the technical exhibit as a feature of the annual convention. For many years *The MODERN HOSPITAL* printed the official convention program, and Dr. Ball and his advertising staff assisted in the promotion and sale of exhibit space to manufacturers.

From the beginning, Dr. Ball had

been interested in the education of administrators as a means of improving hospital service. With the editors, he worked out a series of reading courses or lessons in hospital administration which were published in the magazine, and, in 1920, he helped persuade the Rockefeller Foundation to organize a committee to study the feasibility of setting up a formal program of university education for administrators. These studies were the forerunner of the first graduate course in hospital administration, established at the University of Chicago in 1934. His interest in the education of administrators continued undiminished until the time of his death, when the big idea he had more than 30 years ago had proliferated into the 14 university programs that serve the field today.

As he had with the American Hospital Association, hospital industries, and the educational programs, Dr. Ball had also taken a hand in organizing services to meet the special needs of the nation's Catholic hospitals. Early in the development of the American College of Surgeons' standardization program it had become apparent that one of the major problems in communication was the inability of Catholic sisters to take an active part in the meetings being held around the country. A separate conference in which these and other Catholic hospital problems could be discussed freely was indicated, and Dr. Ball worked with Father Moulinier of Marquette University to organize the group that became the Catholic Hospital Association of the United States and Canada. The first meeting of the association was held in Milwaukee in 1915, and its transactions were published by *The MODERN HOSPITAL* and distributed to Catholic hospitals and church officials throughout the two countries. Later, in response to special needs, Dr. Ball helped Father Moulinier to arrange with the Bruce Publishing Co. of Milwaukee for publication of an official association journal, *Hospital Progress*.

Years afterward, when the journals of the American Hospital Association and the Catholic Hospital Association had become, in one concept, competitors of *The MODERN HOSPITAL*, Dr. Ball liked to point out to his associates in the company that it was he, in a way, who was responsible. Actually, however, he took the larger view that competition among journals was good for the cause of better hospitals. "The purpose should not be competition

with existing publications but basically to serve the membership and the field as a whole along association lines," he wrote when an official of the American Hospital Association asked him for advice about that association's journal. "Possibly the most valuable service of *Hospitals* would be through an intimate association journalism, maintaining a close contact with state and regional units, adequately departmentalized to cover all major activities such as Blue Cross, legislative problems within the area, news of personnel, etc. Consider also the responsibility of *Hospitals* to present detailed studies of live subjects and then reprint these articles as bulletins of the A.H.A." It was sound advice, and, in large part, it has been carried out. So also was the advice he gave Dr. MacEachern and others at the time the International Hospital Association was organized. "You could not have rendered the association finer or greater service," Dr. MacEachern wrote Dr. Ball in 1939, following one of its early meetings. "I cannot thank you enough for the space you have given this program." As an additional contribution to the cause of better hospitals everywhere, the company in 1940 published *El Libro del Hospital Moderno*, a Spanish-language edition of the *Hospital Purchasing File*.

Concerned as he was with hospital affairs, Dr. Ball was not too busy to take note of developments in another rapidly emerging profession, public school administration. Most education magazines had failed to gauge the declining influence of the lay school board member and the ascendancy of the professional administrator as a dominant factor in public education, but Dr. Ball saw the big picture and, in 1928, he established *The Nation's Schools*, now the leading journal in its field. Another magazine in the educational field, *College and University Business*, was launched in 1946 following preliminary studies which indicated divergent interests and needs among public school and college administrators.

In recent years, Dr. Ball had relinquished active management of the company's publishing properties to younger men in the organization and occupied himself with other activities, including the series of articles he wrote for *The MODERN HOSPITAL* under the title, "They Made Hospital History," and a monumental history of hospitals on which he had been working for the

Raymond P. Sloan Is New Modern Hospital President

CHICAGO.—Raymond P. Sloan has been elected president of The Modern Hospital Publishing Co., directors of the company announced here last month following the death of Dr. Otho F. Ball, founder of the company and its president since 1913.

Mr. Sloan, who will make his headquarters at the company's eastern offices at 101 Park Ave., New York City, joined *The MODERN HOSPITAL* in 1933 as associate editor. He was editor for many years and has recently been vice president and editorial director, and a member of the company's board of directors.

Mr. Sloan is well known to hospital people as a convention speaker and lecturer. He is on the faculty of the program in hospital administration at Columbia University and is the author of two books, "Hospital Color and Decoration" and "This Hospital Business of Ours," a book for hospital trustees published last year. He is himself a trustee of the Memorial Center for Cancer and Allied Diseases in New York City.

Peter Ball, son of the founder and eastern advertising manager for the company, has been named to the board of directors, it was announced.

last two years. Shortly before his death, he was pleased to have a publisher indicate keen interest in a rough draft of the book—a massive manuscript which was not yet complete but which indicated beyond any doubt that he still saw the big picture. His work on the book had been interrupted last winter by a serious operation, but a few months at his home in Florida put him back in shape, and he returned to Chicago in April, his enthusiasm as undampened by illness as it was by age.

For the last eight years, Dr. Ball had lived alone in his Chicago apartment. Mrs. Ball, whom he married when he was a young practicing physician in St. Louis, had died in 1945; his son, Peter, was in New York as eastern advertising manager of the company, and a daughter, Mrs. Gerald Wellesley, lived in England. Loving company as he did, Dr. Ball often had friends in for dinner, talk and bridge, and another favorite diversion was to get away with a good companion for a week's fishing in Canada, usually on lakes which could be reached only by small, chartered airplanes—providing an excitement that he relished.

He relished the excitement, and the fishing, and the companionship, as much on his last trip to Canada, in July this year, as he did the first time, years ago. "We had some rough weather," his fishing partner said a few days ago. "One afternoon, in fact, we got caught in a heavy storm. We were shipping water with every wave, and I thought we were going to capsize—in 30 feet of water. We were being

swept toward the shore, and as we got closer Otho leaned over and pointed. 'Look at the beautiful moss on those rocks!' he shouted. I was afraid we were going to drown any minute—and he was admiring the scenery!"

Dr. Ball returned to the office on July 13, tanned and refreshed, eager to get back to work on his book, full of plans for the magazines and the company and, as always, for the improvement of hospital service. The day before he died, he had a long conference about the book with an old friend and fellow medical publisher, Dr. Morris Fishbein. "Otho was as alert and fresh as I have ever seen him," Dr. Fishbein said afterward. "His mind was terrific, and he was clearly planning way ahead."

The long-term plans he was making will unquestionably be carried out, but not by Dr. Ball. On July 19 he died at his home of a coronary occlusion. Among the papers that an associate found in Dr. Ball's desk, a few days later, was a letter he had written to a friend in 1942, following the death of the hospital man whom he respected most of all, Dr. Goldwater. "His outstanding and inspiring leadership will be sadly missed in the efforts which lie ahead," Dr. Ball had written, "but I have faith that his sound philosophy has been absorbed and accepted by many potential leaders who will carry on a constructive program adjusted to the rapidly changing conditions of our time."

In the opinion of those who knew him, the same thing could be said today of Otho Ball.

Blue Cross Slips Are Showing

Unless the plans return to their original philosophy of social action, they will lose their only real reason for existence—to help solve our basic health problems

THE spectacular growth of Blue Cross began slowing up in 1947. The curve showing national net increase in membership has flattened out to a point where now we little more than hold our own. Blue Cross appears to be standing almost still, while those of us responsible for its direction try to determine which road to take. The forces of expediency push us in one direction; the philosophy of community service in another.

The time has come for us to re-evaluate our program and determine what Blue Cross is and what are our goals and objectives.

THIS IS WHAT WE SAID

We have said that Blue Cross was organized to solve the social and economic problem of making the services of the hospitals available to the people of the community. We have said that these services should be provided on a voluntary prepayment basis which any self-supporting person could afford. We have said that Blue Cross is a nonprofit community service organization using the magic of averages for the benefit of millions. We have said that we have solved the problem of meeting the unpredictable cost of hospitalized illness by successfully merging a broad insurance principle with a service organization.

But since the birth of Blue Cross—an idea sired by adversity out of depression—an idea grasped by hospitals as a means of financial salvation—the economic weather has changed. The winter of economic depression was followed by a spring and summer of unprecedented business activity. Record high individual and national incomes were accompanied by spiraling infla-

From a paper presented at the annual conference of Blue Cross Plans, 1953.

JAMES E. STUART

Executive Vice President
Hospital Care Corporation
Cincinnati

tion. At the same time great changes in the practice of medicine, in the care and treatment of the sick further dislocated the Blue Cross economy.

Our original philosophy of action, the concept of service to the community, the vision of social purpose, changed little during the spring and early summer of our season. But as we grew in number to astound our most hopeful progenitors, our financial problems grew even faster. The principle of insurance, originally merely a tool of a social program, came to dominate the program. We found ourselves thinking and speaking in insurance terms, and, in some areas, using the methods, technics and concepts of traditional commercial insurance.

This retreat from basic philosophy of purpose is understandable whether it is justifiable or not.

Changing conditions caught Blue Cross plans between the upper millstone of increasing utilization and the nether millstone of spiraling costs.

Since 1942, hospital costs have been increasing on an average of 1 per cent a month. To our consternation, we have seen the cost to Blue Cross for old services doubled, costly new medications added, and the usage of both old and new services increased by 50 per cent. To meet this alarming situation with a minimum loss of membership, we raised fees too little and too often.

We did things which could be disastrous to our program and to the voluntary hospitals of this country.

We offered a multiplicity of con-

tracts at various prices with varying benefits.

We placed indemnities on services and fixed cash allowances toward room and board.

We eliminated services which had formerly been provided.

We introduced cooperative and deductible contracts requiring the patient to pay fixed amounts directly to the hospitals.

ABANDONED THEIR PHILOSOPHY

We thus abandoned, to a varying degree among the Plans, the original philosophy and the basic concept of Blue Cross as a community service organization, and placed ourselves upon the same footing as that of commercial insurance companies who deal in indemnities, restrictions, group selection and cash limitations. For the first time, we made it possible for insurance companies to compete with us and to underbid and take from us groups which had contributed most to our reserves. In our frantic attempt to make income equal outgo, we took on the trappings of commercial insurance, and for an unpalatable mess of commercial pottage, we jeopardized our birthright of community support.

While Blue Cross membership increase began to slow up, the growth of commercial insurance in the last five years has been phenomenal. Economic conditions and those who write hospital insurance for a profit have maneuvered us into a battle of competition on grounds chosen, long occupied and deeply entrenched by the commercial insurance carriers—a field on which our battle can't be won but certainly may be lost.

Blue Cross has become more and more identified in the public mind as an insurance operation providing lim-

ited benefits under certain conditions, as has been done by insurance companies for generations. We are losing to a varying degree in individual areas our identification as a nonprofit community service entitled to unquestioned support from the pulpit, press and public.

The time has come to determine whether we perform an insurance function and nothing more or whether we should recapture the vision of our youth, the philosophy of social action upon which we were founded.

If our function is simply to provide hospital insurance to the people who wish to buy it from us in preference to buying it from long established companies with more adequate reserves, then we should rid ourselves of our responsibility to hospitals, completely abandon the service principle, eliminate the right to continuous coverage, forget about community enrollment, put more fine print in our non-group contract, start a program of cancellation when the risk deteriorates, rate each group according to its own utilization, throw off the cloak of community service and stand forth for what we are: 87 relatively small local companies writing hospitalization insurance.

CAN SOLVE BASIC PROBLEM

But that need not be our function or our destiny. Blue Cross still can be the instrument to solve a basic health problem which can be solved only by Blue Cross or the government. Commercial insurance companies, dealing in indemnities rather than service and limiting coverage to selected risks, cannot solve it since they assume no obligation to meet the needs of people or the needs of hospitals. The instrument which solves this problem must function to meet both these needs, must see the problem of hospitalized illness in terms of the care needed by people—unhampered by underwriting considerations of age, sex, or place of employment.

If Blue Cross has a unique social task to perform which cannot be performed by the insurance companies, and if 87 Blue Cross Plan boards and directors can look at Blue Cross and agree that the original concept of community service is sound and that basic principles are still applicable, then we have important and urgent tasks to be performed in several areas.

First, we must work out a method

of living with our participating hospitals which, either by law, by contract or both, guarantee to provide the services we list in our subscriber contract. This relationship cannot be worked out by insulating ourselves from the hospitals, by swearing at them from a distance, or by making them the villain in our rate increase explanation.

From topics discussed at many of our meetings, it would seem that the biggest problem to be solved by Blue Cross and the hospitals is the method of paying for members' care. Here we waste time, effort and money in treating the symptom and not the disease. All methods of reimbursing hospitals are imperfect, yet any reasonable method can be made to operate satisfactorily if it functions in a climate of mutual confidence, understanding, cooperation and good will. And even the undiscovered perfect method will fail in an atmosphere of fear, mistrust and suspicion.

We must provide organized channels of communication and understanding between us and the hospitals. We must organize methods of resolving petty differences before they develop into problems. Open, free, frank discussions of mutual problems offer the best hope of developing mutual trust and confidence necessary to our success, and the formalized machinery to permit such discussion must be available at all times.

Through such machinery we have a chance to have the hospitals recognize their responsibility for self-discipline in actions which affect Blue Cross and Blue Shield members.

We have a chance to secure active support from hospitals in programs of control to protect Blue Cross from abuse and over-usage.

We have a chance to get the hospitals to assume the responsibility inherent in their relationship to us and to recognize Blue Cross for what it is—the only agency authorized to offer their services to the public on a pre-payment basis.

We have a chance to get them to accept reimbursement for services to members on a stable contract with payments based upon reasonable and justifiable costs of efficient operation. Without this, the Blue Cross ship is all sail and no anchor.

Through an organized relationship we might change an attitude which now exists in some areas—that Blue Cross is an insurance program owned

and operated by and for the benefit of the hospitals, with Blue Cross forced to pay the hospitals' uncontrolled billing charges—disastrous to Blue Cross immediately and to the hospitals eventually.

The task in the field of hospital relations is to restore and put new life into an original concept: that Blue Cross is an important part of the hospitals, the service arm, the public relations department; that Blue Cross is the hospitals' own program; that Blue Cross is the hospitals and that the hospitals are Blue Cross, operating together in a close and effective partnership to solve the community's problem of hospital care for the sick.

WORK WITH MEDICAL GROUP

The second task is to establish a close and continuing relationship with organized medicine for the protection of our program and the preservation of the voluntary systems of health care. This will require more than mere representation on the Blue Cross board of trustees by the medical profession. Again, here we must develop methods of effective communication through the organization of local or regional committees in which members chosen by the profession—not by Blue Cross—would have an opportunity to advise and assist in the formulation of major policy. Such organization may well extend to a committee of the local staff of each participating hospital, to which matters involving the over-all voluntary health care system might be referred by the administrator. The problem here is primarily one of education, and the more members of the profession that can have a direct relationship with Blue Cross the better. With the medical profession, as with the hospital, our task is to set up an effective partnership to achieve common goals.

Through such organized machinery, we have a chance to set up self-imposed voluntary controls for our protection. The hospitals merely determine the charges for the services and commodities they provide. The doctor determines when, how often, how much and how long these services will be provided. From a very practical point of view, he determines whether Blue Cross lives or dies. The urgency of the task in this area seems apparent.

The third task has to do with the consumer—the public, the present and potential Blue Cross subscriber. Somehow we must inform him what Blue

Cross is, how it operates, and of the community and hospital responsibility entrusted to our care. Somehow we must explain hospitals to him, why it costs money to provide care, why hospitals are different from any other type of business. We must make him understand what service benefits are, how important is the right to continue coverage after loss of job or retirement, and why only Blue Cross can solve the community's problem of care for the ill through a voluntary program. Somehow we must give him adequate representation at the policy making level.

Then, we must make it easy for the public to enroll. Blue Cross must be made available—accessible on some sound basis to all the self-supporting people of the community. We must make it possible for professional groups, community groups, individuals, direct pay subscribers to obtain and continue our protection on some basis that is reasonable and financially possible for them and for us.

KEEP MEMBERS INFORMED

Then, after the member is enrolled, we must keep him informed of what he has and the importance of keeping it. We must provide the subscriber with coverage that includes all the services of the general hospital for an adequate number of days for all the diseases treated in a general hospital.

If we have learned anything in the last five years, we have learned that people want their hospital bills paid. Not only have they demonstrated their willingness to pay for even limited coverage by assuming our ever increasing fees but, to a far greater extent, they have shown this willingness by the payment of higher commercial insurance premiums for fewer benefits.

For the low-income, nonwage group and for many of our present and potential direct-pay subscribers we must work out some type of basic service program providing minimum services at a lower rate than we are now charging, with payment of fees accepted at more frequent intervals than is now generally permitted. Here we have a real problem, relatively unsolved, but the job must be done.

Probably our most difficult job is the protection of the subscribers' pocket book, to see that the charges we must make for adequate and comprehensive coverage are reasonable and within the ability of the ordinary working man to pay.



All of us know there will come a time in this continuous increase in subscriber rates when Blue Cross will reach the point of diminishing returns and the hospitals' losses in collections will increase in proportion.

When the public is no longer able to pay our rates, Blue Cross becomes meaningless and without function and government will be forced to provide a program of health insurance. The hospitals themselves will demand it.

Our success in keeping our rates realistic to the lower economic half of the population will largely be determined by our ability to make the hospitals and the medical profession effective allies and partners in a common social effort.

The next task—and its importance need not be stressed—is to develop the leadership to carry out a program far more difficult than that of selling insurance. We must find and develop personnel for a great social engineering job, for creating and operating an effective instrument for solving the universal social problem of meeting the cost of hospital care.

We must have leaders willing to pioneer in areas yet unexplored, for example, coverage for ambulatory diagnostic service and programs with government for care of the indigent. We must develop leaders who can lead a national movement and achieve a high level of unity and cooperation among 87 autonomous Blue Cross plans.

Within the next few years the American people will choose an instrument to provide security against the cost of illness. If we in Blue Cross and our friends in Blue Shield fully develop the principles upon which we were founded, if we offer a satisfactory solution to the problem of meeting the unpredictable cost of illness, then the people will not be forced to set up a system through government, which, to be successful, would have to be universal and compulsory. Blue Cross and Blue Shield now have the time and opportunity to demonstrate that the problem of health care can be solved without compulsive legislation, and we can be the chosen instrument to solve it.

Let me remind you with all the force

at my command that for government to do this job requires no constitutional change in our basic laws for we long ago adopted the second unwritten amendment to our Constitution. The first such unwritten amendment was to the effect that no state might secede from this Union. That was not proposed by two-thirds vote of the Congress and ratified by three-fourths of the states, but was initiated on the field of battle, and ratified by the fortunes of war.

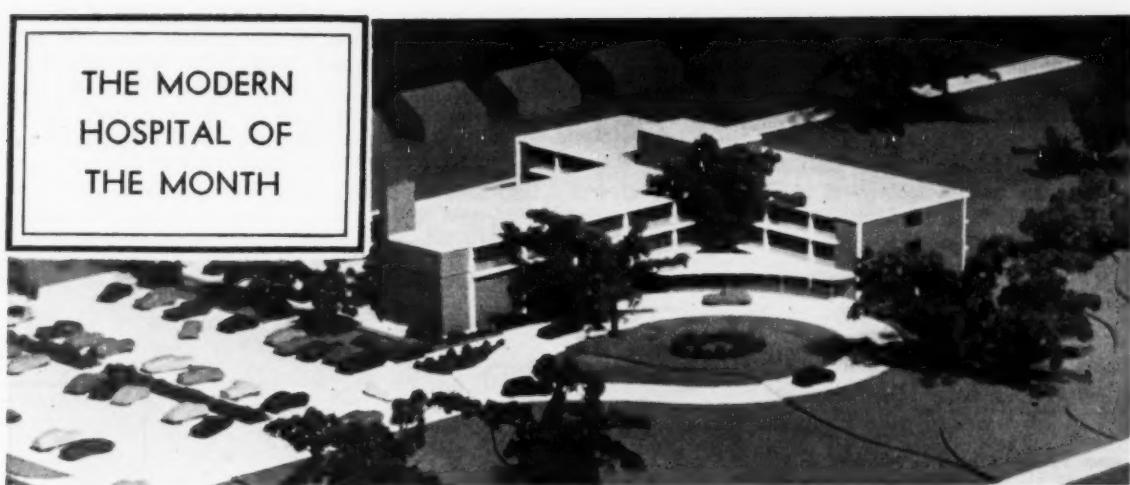
The second unwritten amendment to the Constitution is that government is responsible for the welfare of the individual citizen. This amendment was engendered by our greatest economic depression and approved by the people at every presidential election since 1932.

WE HAVE ACCEPTED IT

We have already implemented this amendment to a large extent. When you are over 65 and in need, the government will help you. If you are unemployed and can't find work, the government will assist you. If you are a mother with dependent children, aid will be granted. If you are indigent and can't make a living, relief will be provided. In other words, the government already guarantees you some security against old age, unemployment, widowhood and inability to earn a living. The next logical step is to provide medical and hospital care when you are sick. This step will not be taken as long as a reasonable standard of health care is provided to the people generally. But if there comes a day when we are unable to provide the ordinary citizen with satisfactory protection at reasonable cost against the cost of illness, that need without question will be met by government regardless of what political party is in power.

To accomplish the tasks before us, we must go forward with our philosophy of social action, further develop the principles which gave us our growth, and further implement the concept which made us great. We must agree as to what we are and where we are going. We must recapture the evangelistic spirit which characterized Blue Cross in its youth. We in Blue Cross must steer our course by the fixed stars of community service rather than by the moving lights from the near-by shore of expediency or by the contrary currents of commercial competition.

**THE MODERN
HOSPITAL OF
THE MONTH**



ARCHITECT'S MODEL. FAYETTE COUNTY HOSPITAL, VANDALIA, ILL.

The County Got the Most for Its Money

MORRIS HERTEL

Hertel, Johnson, Eipper, Stopa & Culver Architects, Chicago

HERMAN SMITH, M.D.

Consultant, Chicago

THE 30 bed Mark Greer Hospital, Vandalia, Ill., has done an excellent job of caring for its patients, but owing to its size, it can provide only limited services. Five years ago when the Hill-Burton Act was passed, the

people of Fayette County began to consider the construction of a new hospital. After four years of organizational work and after passage of authorization of a million dollar bond issue, the Fayette County Hospital Dis-

trict, representing 30,000 people, employed an architect and began to plan the hospital.

The total project cost, consisting of the bond issue, Illinois state aid, and federal aid, was given to the architects with the stipulation that the county wanted the greatest number of beds and facilities for its money. It wanted a building that would reflect the function of its services, and reveal its purpose. It wanted the building to imply efficiency, neatness, orderliness and authentic beauty and, above all, it wanted flexibility.

The hospital is located in a quiet residential neighborhood not far from the center of town, adjacent to the Mark Greer Hospital and at the end of a dead-end street. Beautiful, large white oak and hickory nut trees enclose the property on two sides, and comparatively new and attractive homes enclose it on the other two sides. In the orientation of the building, prime consideration was given to the fact that patient rooms should face south to take advantage of the winter sun and that the patients, when looking out of the windows, should have a pleasant view, not of passing

OUTLINE OF CONSTRUCTION COSTS

Total construction cost includes group I equipment (without third floor unfinished space)	\$1,241,092.00
Cost of third floor unfinished space	\$ 36,131.00

Detailed Analysis

General work	\$ 762,877.00
Mechanical	334,000.00
Electrical	99,500.00
Elevators	41,000.00
Kitchen equipment	26,400.00
Laundry equipment	13,446.66

Total construction cost (based on contracts awarded)	\$1,277,223.66
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Groups II & III equipment (estimate)	\$ 150,000.00
Site survey and soil investigation	839.00
Architect's fees	76,633.42
Owner's supervision	12,000.00
Total project cost	\$1,516,696.08

automobiles and trucks, but of the quiet and pleasant setting provided by the surrounding trees and extensive lawn.

Through the use of concrete overhangs over the windows the high, hot summer sun is kept out of the patient's room, but the low, warm winter sun is admitted. The majority of the patients' rooms face south and

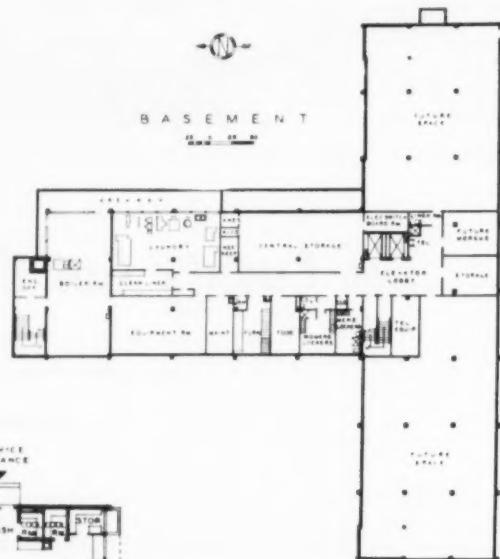
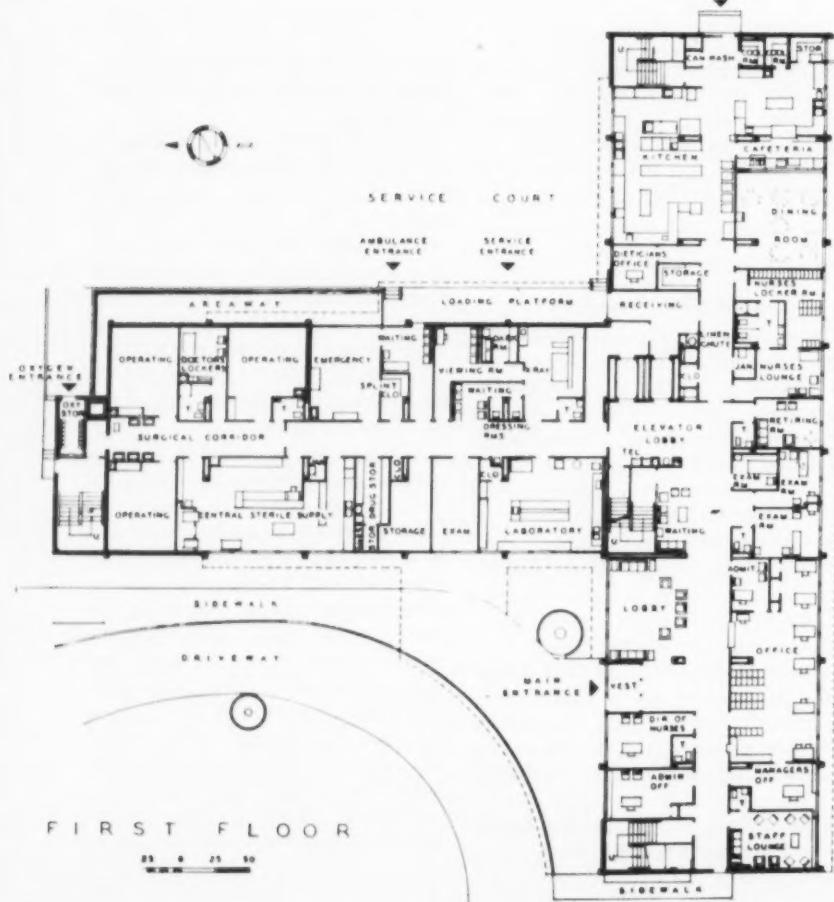
take full advantage of this "solar planning" principle, with an expanse of glass the full width of the room. The sun is further controlled in each patient's room by draperies suspended from a concealed track.

The concrete sunshades serve another use as well. They provide a platform for window washers. Inasmuch as all rooms have fixed windows,

the window washers can wash the outside of the windows from the sunshades without disturbing the patients.

It was agreed at the outset that large nursing units—up to 50 beds—would provide for an efficient operation, provided certain extra facilities were integrated into the units, such as a lavatory and toilet with a bedpan cleansing unit attached for each bed-

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month



Above: Part of the basement is occupied by boiler and laundry room, linen room, central storage, and lockers for employees. Space is provided for future expansion. Left: Surgery, laboratories, dietary department, and the various administrative offices are on the first floor. Three outpatient examining rooms are conveniently located off the waiting room adjacent to the main entrance and lobby.

room, and a two-way intercommunication system between each bedroom and the nurses' station. The length of nurses' travel from the nurses' station to the farthest double room is 75 feet in one direction and 88 feet in the other. In view of the labor saving devices mentioned, these distances are reasonable.

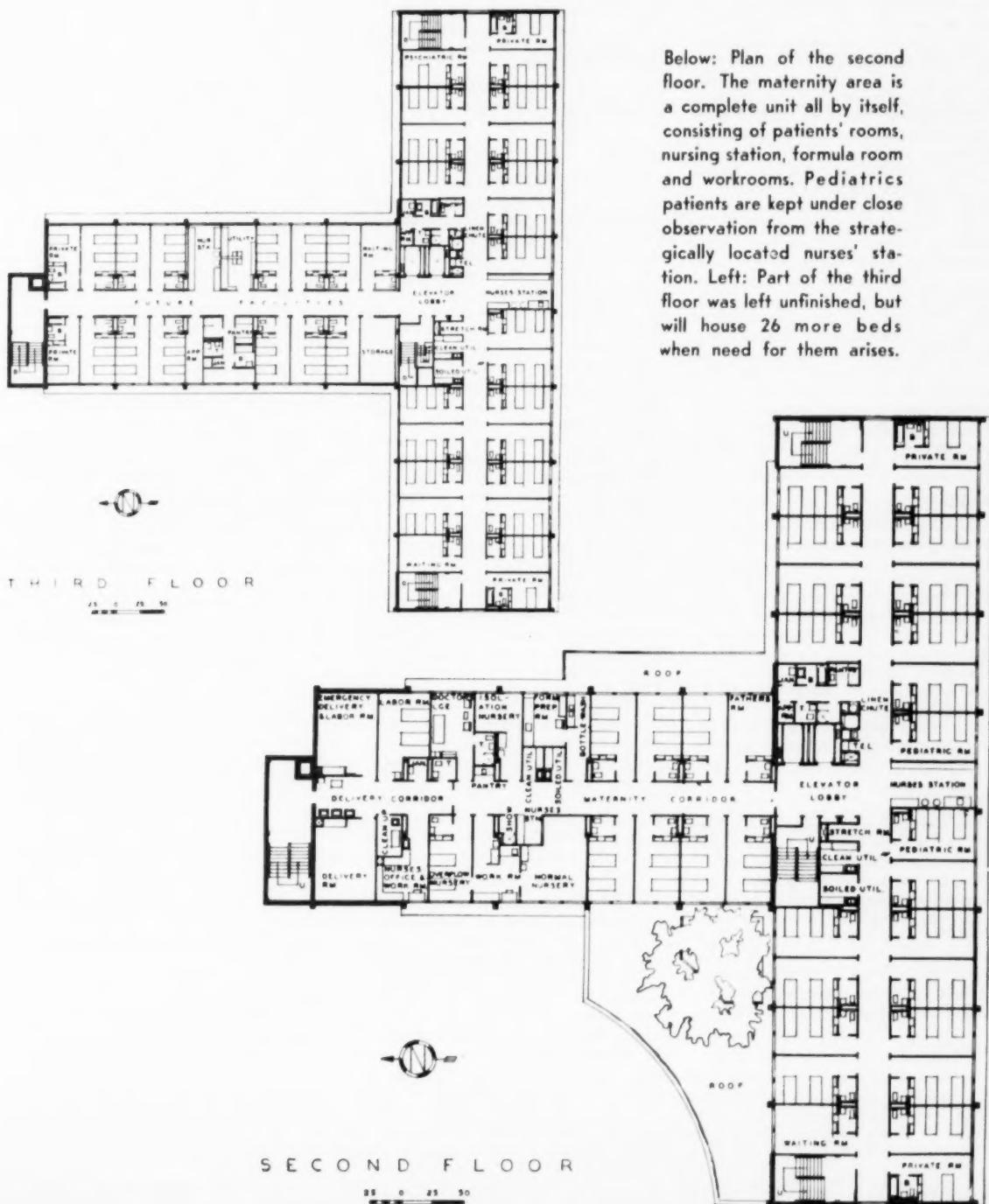
All of the auxiliary services are con-

centrated in the corridor at the center of the long wing convenient to the nurses' station.

The basic unit of the plan is the patients' rooms, which are 12 feet wide; two rooms make up a 24 foot bay. This bay was made typical throughout without deviation. The resulting plan became simple, orderly, efficient and clean cut. The patients'

rooms are in the front of the "T" on the second and third floors. The obstetrics department occupies the stem of the "T" on the second floor, and the surgical suite occupies the space below on the first. Offices, kitchen and so forth are in the front of the "T" on the first floor.

It was decided that if the bids came within the budget and funds were



Below: Plan of the second floor. The maternity area is a complete unit all by itself, consisting of patients' rooms, nursing station, formula room and workrooms. Pediatrics patients are kept under close observation from the strategically located nurses' station. Left: Part of the third floor was left unfinished, but will house 26 more beds when need for them arises.

available, the third floor rear wing should be built now and left unfinished. When the time arrives and there is a need for more beds, this area can be completed and 26 more beds can be provided for. The bids were well within the budget and that unfinished space will be built now.

PATIENTS' ROOMS

All patients' rooms, except the four private rooms, are the same size, i.e. 175 feet square. They will accommodate two beds, two bedside cabinets, two chairs, lamps and so on comfortably. Each bedroom has an adjoining toilet room with a door so located that patients or visitors cannot look directly into it from the bedroom. The door swings into the toilet room, so as not to interfere with the flow of traffic through the entry. Where toilet rooms are small, doors should swing out but because the room is 6 feet long, the door can be swung inward without fear of a fainting patient's falling against it.

The toilet room is separated from the patient's bedroom by a wardrobe unit. It consists of two generous, attractive, wood wardrobes, with extension arm clothes hangers and two shelves above each one. Between the wardrobes is a two-shelf, two-door cabinet near the floor for storage of the patients' belongings. Similar wood cabinets are placed 62 inches above the floor for blanket storage. On the toilet room side of the wardrobe there is an attractive stainless metal cabinet of four open shelves, which will hold an emesis basin and a urinal, cosmetics, shaving equipment, and medicines.

SURGERY

The surgical, emergency, x-ray and laboratory departments were placed in the first floor north wing, all accessible from the main lobby, and from the emergency court. This is a particularly good location in that all interrelated activities are adjacent to each other. People can go to the emergency, laboratory or x-ray departments from the service court or from the main lobby without going through any other portions of the hospital. Two operating rooms will be equipped alike and the third one will be equipped for cystoscopic work.

MATERNITY

The maternity department is a complete unit in the north wing. It has complete nursing unit consisting of a nurses' station, clean and soiled utility rooms, pantry, clean-up rooms, and nurses' workroom. Bottles are washed and formulas are made here. If the demand arises for more medical beds and fewer maternity beds, four rooms can be closed off from maternity section and become a part of the medical portion of the hospital.

PEDIATRICS

Inasmuch as children in any stage of illness need close observation, the pediatrics rooms are placed adjacent to the nurses' station. A double insulating glass window between the nurses' station and the pediat-

rics rooms will permit considerably more than the normal amount of observation. A drapery on the nurses' station side will permit control on their side of the window, and a drapery on the patients' room will permit control from that side should the room be used by an adult patient who does not require constant observation.

The pediatrics rooms are the same size as other patient rooms and can be used as adult double rooms when not required for pediatrics patients.

ADMINISTRATIVE OFFICES

The administrative offices are off the main lobby away from noise and traffic, and are located on a dead-end corridor.

Three outpatient examination rooms are conveniently located off the waiting room adjacent to the lobby.

A retiring room has been provided for those who wish a quiet and restful room for consultation, solitude or meditation.

KITCHEN

The kitchen and dining room are on the east end of the main floor. The kitchen is easily accessible from the receiving room. Some foods will be brought into the receiving room and taken to the basement food storeroom. Perishable foods will be brought into the east end of the kitchen directly from the service court and then placed in the walk-in coolers or the day-storage room.

The dietitian's office is adjacent to the kitchen. It is located so that salesmen, suppliers and others can come to this office without coming into the kitchen.

The dining room is set up for cafeteria style of serving and is easily accessible for staff, nurses, patients or visitors.

The food service consists of food carts with cold and hot sections.

VISITORS' WAITING ROOMS

One visitors' waiting room is located on each of the nursing floors. To provide for maximum flexibility the room is the same size and equipped the same as a double room. In case of an emergency, these two rooms could be used as patients' rooms. They are far away from the nurses' station so that visitors will not be able to loiter around the station and interfere with the normal duties of the nurses.

The fathers' waiting room in the maternity department is just off the elevator lobby, located so that fathers can wait in that department and still be far enough from the nurses' station so they will not bother the nurses.

ELEVATORS

The two elevators are immediately accessible to the main lobby, the surgical wing, the service entrance and the kitchen. Inasmuch as one elevator is adequate to accommodate normal staff and visitors, the other can be used exclusively at mealtimes for food service and, in the morning, for all patient and personnel traffic to and from the x-ray department, surgery, laboratory and emergency departments. When not in use for those services it can be used for moving items to and from the main storeroom in the basement. During

visiting hours it can be used with the other elevator for visitors. The elevators are equipped with "hospital emergency service," which by the turn of a key prevents the elevator from responding to calls from the push buttons and thus allows personnel to have uninterrupted use of it.

A private corridor has been provided on the first floor so that doctors, nurses and surgical patients can go from the surgical corridor to the elevator without going out into the public elevator corridor.

AIR CONDITIONING

A ventilating system has been provided which directs the flow of air from the corridor into the patient's room so that contaminated air cannot flow out of one room and into another. A diffuser unit is placed in each room. In the patients' rooms it is located in the furred down plaster ceiling of the vestibule adjacent to the toilet. The air rises from the basement in 4 by 5 inch round ducts located in the pipe spaces adjacent to the interior columns and then branches off at the ceilings to the diffuser units in the rooms.

WINDOWS

Operating windows of any type permit air to infiltrate around the perimeter. The only way to reduce or stop such infiltration is to eliminate the operating windows and use fixed glass. That was done throughout, except in eight rooms in which windows with hoppers are provided. These rooms will be given to patients who have phobias about closed windows, even though the room is completely air conditioned.

With 235 of the 243 windows being the fixed glass type it is expected that there will be a substantial savings in housecleaning and maintenance.

The insulating efficiency of 1 inch double insulating glass is twice that of a single thickness of $\frac{1}{4}$ inch plate glass. In order to keep heat loss to an absolute minimum and, therefore, proportionately reduce the size of the heating and air-conditioning system, as well as the operating costs, the double insulating glass is used throughout the entire building.

WALL PANELS

The spandrels are metal insulated panels 4 inches thick made up of $\frac{1}{8}$ inch thick aluminum sheets on the exterior, fluted with tiny knife cuts to reduce reflections and with $\frac{1}{8}$ inch thick sheets of galvanized sheet metal, on the interior, painted to match the interior walls. Three inches of rigid insulation is placed between these two sheets of metal. The resulting wall has a heat transmission coefficient of 0.10, that being the same as for a 16 inch brick wall with a 1 inch dead air space plus 1 inch blanket insulation, plus gypsum lath and plaster.

ACOUSTICAL TILE

All ceilings except those in the basement are covered with acoustical tile. In the patients' rooms, the tile is applied directly to the concrete slab, in the corridors and other rooms where ceilings are furred down to conceal exhaust ducts, the acoustical tile is applied to suspended metal lath and plaster ceilings.

Hospitals Endure Under Socialized Medicine

After five years, Britain's National Health Service is still popular, still beneficial to many, still imperfect—and not needed here

ROBERT M. CUNNINGHAM Jr.

FOR a quick summary of the present status of Great Britain's National Health Service, which was five years old last month, one might do worse than rely on the judgment of a doctor-army officer who is also a Conservative member of Parliament, Col. Malcolm Stoddard-Scott. "The service has come to stay," Col. Stoddard-Scott said during a recent election campaign. "It is one of the most popular things in the Kingdom, and it has achieved much—but at the same time there is room for improvement."

As a Conservative M.P., Col. Stoddard-Scott could be expected to take a critical view of the health service, which was introduced by the Labor Party now in opposition to the government. Actually, Conservatives at the moment are probably more satisfied with the way the service is working than are Labor members, who view with alarm—sometimes expressed in shrieking tones—the introduction of certain modifications in the service and the Conservative tendency to look around a bit and tighten things up here and there, instead of plunging ahead in the original, free-beer-for-everybody spirit.

The thing that worries some members of the Labor Party, and notably Aneurin Bevan, former Minister of Health when the Labor Party was in power, is that the Conservative modifications may be the thin end of a wedge that will eventually separate

the average Briton from the free medical and hospital care that he has come to regard as a God-given right, like sunshine. In a recent Parliamentary debate on the health service, for example, Mr. Bevan took a dim view of the appointment by the present Minister of an independent committee to review the cost of the service and suggest means of ensuring the most effective control and efficient use of its funds. "We are apprehensive because of the language used in the terms of reference [of the appointment] and also because that language follows upon certain actions of the government which lead many of us to believe that the government are not particularly enthusiastic about the defense of a free health service," said Mr. Bevan. Later in the debate, he warmed to his work and referred to the appointment as "a cheap, calculated maneuver against the welfare of the health service," and, still later, "a subtly-laid plot to provide the administration with an excuse for a further attack on the service."

While the report of an independent committee of inquiry, in Britain and elsewhere, may always be used as a device for the attainment of previously established goals, the procedure is common and reasonable enough as a means of seeking administrative economy and efficiency to suggest that the vigor of Mr. Bevan's attack may have owed something to the political desirability of drawing public attention

away from the fact that it was the Labor Party in 1951, and not the present government, which introduced the first of a series of charges for service that modified the original health act. Whatever the intentions on either side, the argument today, in and out of Parliament, concerns administrative methods and the extent to which health services should be free to the consumer. There are many still who regret it, but there are few if any who would disagree with Col. Stoddard-Scott's judgment that the service has come to stay.

As they were in the beginning, the regrets today would be found chiefly among older doctors whose private practice has been dwindling steadily for five years, and less among the younger doctors who are busily, and not too unhappily, employed in the care of the sick; chiefly among general practitioners whose position has improved remarkably in the last two or three years but who must still grapple with administrative forms and regulations and treat many patients who are more curious than sick, and less among qualified specialists serving full time or part time on hospital staffs; chiefly among administrators of the former great voluntary hospitals which have lost some independence and gained little, unless it be an exchange of creeping insolvency for restrictive Ministry budgets, and less among administrators of former municipal or

local authority hospitals which have escaped from the professional and financial cellars in which they cowered for years before the act; chiefly among the former patrons and governors of voluntary hospitals who have lost incentive and importance and authority, and less among the voluntary members still sitting on teaching hospital boards and those on regional boards and hospital management committees; chiefly among the well-to-do who must accept blindman's choice of doctor and hospital under the act or pay dearly for private care when they are already taxed to support the service, and less among the great, borderline middle classes who are at last relieved of the nagging fear that illness may do them financially. It is unlikely that there are any regrets at all among the poor and the near-poor—for whose protection after all, any government health service is primarily designed.

HOW MUCH DOES IT COST?

In Britain, the great question about a government health service—how much does it cost?—is still not fully answered, and it is around this question that the hottest arguments rage. Essentially, in fact, this is the core of the difference between the government and the opposition. The Labor Party wants to provide a full health service, without cost to the user, implying top priority for health among such other charges on government funds as housing, defense and education. The present government, on the other hand, feels it must first decide how much the nation can afford to spend on health, then provide the best possible service within the established limit. This is a concept that infuriates Mr. Bevan, especially when he considers that in this year's budget the income tax was reduced slightly, whereas the charges for prescriptions, dental service and a few appliances, such as spectacle frames, remained against users of the health service. "Why this idea of an iron law of health payments, reminiscent of the iron law of wages?" Mr. Bevan demanded of the Minister. "The amount of money that the government want to spend upon the health of the nation will depend very largely upon what importance they attach to it as against other demands upon national funds. It will depend upon the morality of the administration engaged in making the assessment. That is why it seems to us that there was something wrong about the morality of a decision



IAIN MACLEOD
Minister of Health

which put super-taxpayers ahead of the treatment of old people in hospitals—something entirely wrong."

In reply, Minister of Health Iain Macleod quoted from an editorial that had appeared in the *London Times*: "Since there is no discernible limit to the amount that might be spent on medical care," this said, "but since in practice a limit must always be imposed, the government have the unenviable task of having to estimate how much of what is spent ought to be spent on public account for health care." The question thus was, Mr. Macleod explained, whether to restore free medicines and dentures, or whether to leave the charges on these services and spend the money elsewhere—such as for improvements in the mental health service. "I certainly agree that there is a moral issue here," he told Mr. Bevan, "but I deny altogether that the moral issue is whether or not parts of the health service should be free. In my view the moral issue is whether, given a limited expenditure on health, one is prepared to put first things first."

The limited expenditure at the moment adds up to £400,000,000, or approximately \$1,125,000,000 a year—a formidable amount, certainly, but actually somewhat less than the estimated 4½ per cent of national income that is spent on health services in the United States. Of the total amount in Great Britain, two-thirds is spent for hospital service—a term, it should be remembered, that includes the services of specialists who care for hospitalized patients. Whatever the exact amount, an American observer visiting British hospitals would conclude right away that it isn't enough. Even allowing a

generous discount for the American tendency to think that what is new and big is necessarily good, British hospitals are outdated, and badly overcrowded, by our standards today. Buildings for the most part are old, with high ceilings, vast windows and wooden floors that make them expensive, if not actually hazardous, to operate. Built for the medicine of another day, they have a disproportionate amount of space for wards, compared to diagnostic and treatment facilities, for today's more intensive care. Pharmacy, x-ray, medical records, pathology and physical therapy are more likely than not to be found in cramped, basement quarters; central sterile supply and recovery rooms are virtually unheard of, and, invariably, emergency and outpatient facilities are inadequate for their huge loads, with the result that disconsolate queues of waiting patients may be found all over the place—in anterooms and corridors, practically in the laps of hard-pressed doctors and nurses, and even, in some cases, outdoors. Everywhere, signs of budgetary strain are apparent. Operating rooms and anesthetic equipment, x-ray and physical therapy apparatus and other professional matériel are up to date, but, obviously, these essentials have been obtained at a sacrifice; beds and furnishings are ancient, and there are far too few of the dishwashing machines, floor polishers, tray conveyors and other labor-saving devices that are such a boon to the hospital economy, which, like our own, is faced with a perpetual manpower crisis.

HIGH STANDARDS OF CARE

The fact is, however, that in spite of handicaps we would regard as insurmountable, the hospitals are usually spotlessly clean, the wards are bright and cheery, the patients are as happy as hospital patients are anywhere, and standards of medical care are unquestionably high under the circumstances. There are a few doctors and nurses and administrators who, fulfilling the gloomy prediction of health service opponents, put on their hats at 5 o'clock and go home, whether their patients need them or not, but there are others, obviously, whose professional esprit and devotion to duty are undiminished by the fact that they are, so to speak, public servants. The wholesale deterioration of hospital service that was foreseen by critics who equated the Welfare State and the end of the world simply hasn't happened.

Whether it will ever happen or not

will depend on the amount of money that can be allocated to the hospital service, and the way the service is administered—the same factors that govern the quality of a hospital service anywhere, whether the jurisdiction is public, private or religious. Some expansion of the hospital establishment is essential; there has not been a single new hospital opened in Great Britain since the war, and the need for beds is apparent in long waiting lists for admission to many hospitals. In some areas patients may wait a year or longer—an appalling obstacle to adequate medical care. "One could spend something like \$700,000,000 on capital expenditure in the mental field alone," the Health Minister said recently. "If one adds to that the question of new hospitals, or the problems of the old, of health centers and perhaps of outpatients, I could probably justify, if medical need alone were the criterion, a capital program of something like \$2,800,000,000. But so, no doubt, could many other Ministers. Therefore, we have this dreadful dilemma, the dilemma of priorities."

MAY BENEFIT FROM POVERTY

Of course, the hospital service won't get \$2,800,000,000 for capital expansion, and it may not get anything. Like a man who is forced against his will to economize, however, Great Britain's health service may ultimately benefit from its own poverty. Compelled to consider alternatives to hospital expansion, government officials and other medical planners are beginning to see the advantages of increased activity in preventive medicine, old people's homes, and "half-way houses," or convalescent centers, where many patients now occupying precious hospital beds can be cared for adequately—at far less than it costs the government to maintain them in hospitals. "It is a proud boast for a Minister of Health to be able to say he has added 10,000 more beds to the hospital resources," Mr. Macleod said in a speech not long ago. "It will be a much prouder boast when he can say we no longer need 10,000 beds because the demand for them is not there."

Granting the happiest circumstances, it is unlikely that Mr. Macleod himself will be making either of these boasts for many years to come. He has his hands full running the existing hospital establishment, some 3200 institutions, and, at the moment, administrators in the hospital service are not



ANEURIN BEVAN
Former Minister of Health

altogether pleased at the way it is being run. For one thing, there is the matter of budgets, a word which is heard at least as often in the vocabulary of socialized medicine as it is in the voluntary lexicon. Hospital budgets are approved annually, running the gauntlet from the management committee, an administrative structure responsible for the operation of groups of anything up to 20 hospitals totaling from a few hundred to several thousand beds, to the regional board, of which there are 14 in England and Wales, to the Ministry itself, where authority resides. Budgets are made up anew each year, and money saved on one year's budget may not be carried over for the following year. "There are those who say that the fact the money has to be returned at the end of the financial year is a disincentive to wise spending in the last months of the year," Mr. Macleod said recently, executing a classical example of the national genius for understatement.

Instead of annual budgets, hospital people want "block grants" covering periods of three to five years—a system, they claim, which would permit more economical planning and do away with the present last minute rush to paint the wards and spruce up the garden with money that would otherwise go down the drain at the end of the year. But a Minister's life is not a happy one, as Mr. Macleod has pointed out. The fact is that two-thirds or more of the hospital budget is spent on salaries and wages, the rates for which are fixed by national labor-management negotiations over which the Minister has no final control, nor can he foresee, any better than other

politicians and their economic advisers, the general price trend, which also affects hospital budgets. So the Minister has resisted the pressure for block grants on the ground that they might easily be more, rather than less, restrictive than annual budgets from the standpoint of the hospital service as a whole. Nevertheless, he has acknowledged, "We must find a way in which we can relate savings to efficiency so that if it is possible to isolate efficiency as a reason for saving, the hospital can get some benefit from it in the succeeding year." The same problems, it should be noted, are not unknown to hospitals outside a national health service.

As it is elsewhere, however, the roots of the hospital budget problem in Britain are not so much in the system as in the money—and there is never enough money. Among other economies he has had to effect, the Minister last year issued an order freezing hospital manpower at its then existing level—a drastic step which he described, with characteristic suavity, in its most elegant terms: "I decided that we would take the establishment on one particular day as the establishment of the hospital," he related, "and that we would ask the hospitals to see if they could, by different methods but not by reducing essential services, do something to contain the level of staff." It was his hope, the Minister explained, to bring about by this method a more equitable distribution of personnel, limiting hospitals already up to a satisfactory ratio in order to help those, notably mental hospitals and sanatoriums, in a less favorable position.

THEY TOOK IT IN STRIDE

As the Minister himself reported recently, it is too early to tell what the result of this move may be, but already there are indications that it may not work out as happily as it was supposed to. Hospital administrators, by long habitude, have developed to a fine art the practice of robbing Peter to pay Paul, and they have taken the manpower order in full stride. "We'll work it out somehow," said one administrator who was questioned about the freeze order when he described how he had just added a couple of registrars, or residents, to his staff to relieve a bottleneck in the outpatient and emergency services. Another, even more frank, told a reporter that he had given a window-washing contract to an outside agency, thus freeing several jobs

in the hospital establishment and providing a cushion to relieve the manpower strain. Such maneuvers, which are repeated endlessly among the nation's 388 hospital management committees, may reveal a near-fatal weakness in a centrally controlled health service, if not in political democracy itself: What is good for the individual is often bad for the group, and what is good for the whole may be bad for some of the parts.

At its best, however, the system is designed to consider whether what is done is good or bad for the part and the whole simultaneously, and, to a degree that is difficult to achieve in a hospital system made up of uncoordinated, autonomous units, this is being done today in the British National Health Service. At a recent meeting of one of the larger hospital management committees in London, for example, the group enthusiastically approved a proposal to send one of its assistant administrators off for several months of intensive training at the administrative staff college run by King Edward's Hospital Fund for London, a hospital foundation, and to continue his full salary *in absentia*. Opinion of the committee, whose members—all serving on a voluntary basis—included businessmen, doctors, nurses and representatives of labor, was that certainly the individual hospital, and the group, would suffer temporarily from the absence of the young man, who cannot be replaced, but that eventually the management group, and the hospital service as a whole, would benefit from his training.

Considering another problem, the group discussed the advisability of expanding the area from which it would accept maternity patients—to relieve congestion in the obstetrical department of a large hospital belonging to another management group serving an adjacent area. On this question, opinion was divided. Possibly envisioning a wider choice of clinical material, one of the doctors was all for enlarging the area and approving admissions solely on the basis of medical interest and need; the hospital's social service department, he implied, was accepting patients, for so-called social reasons, who could just as well be delivered at home—a practice that is still widely prevalent in England, where, unlike the United States, only about 60 per cent of all births occur in hospitals.

Other members of the committee disagreed. A social worker from an-



"What you trades-unionists don't understand, Mr. Pennyfeather, is that nursing is a VOCATION not a trade."

Reprinted from "More and More Productions" by Osbert Lancaster.

other hospital who serves as a member of the committee pointed out that social and medical needs must be considered co-equally, and the committee chairman, a businessman, philosophized that the entire hospital service was planned to make each hospital group responsible for the welfare of a definite constituency. In the end, the committee accepted a compromise proposal to relieve the other hospital as far as possible but to retain priority of admission for mothers from its own area. In the discussion as in the decision, an observer had the feeling that balanced consideration had been given to the divergent interests of the whole and its parts.

PROTESTED RETIREMENT AGE

The same careful blending of near and far vision brought still another problem into perspective in the committee's deliberations. One member, representing a particular hospital in the group, protested vigorously against the automatic retirement, at age 65, of his hospital's pathologist, a man who had given, and was still giving, he said, outstanding service. The hospital's medical committee had asked the regional board to reconsider the retirement order, and the management committee, it was suggested, might tip the scale either way.

It didn't, though. After a discussion that ranged over the subject of older people in industry generally and comprehended the need of the hospital serv-

ice as a whole to have retirement rules providing opportunities for younger men in the service, as well as the unquestioned need of the individual hospital in the particular case, the committee allowed the doctors' request to go along to the board without comment. It was, probably, a question to which there could be no right answer anyway. As somebody pointed out, every case is an exceptional one when it comes to the application of general policies and regulations in the individual hospital.

Luckier, because they are freer to act on their own authority, are the hospitals designated as teaching hospitals under the Health Service Act. Belonging to no management committees and under the jurisdiction of no regional boards, the teaching hospitals negotiate directly with the Ministry on matters of budget and management—a circumstance which has aroused the envy and, in some cases, resentment of those who must make way for the next higher authority in the hospital hierarchy. Some claim this is an unnecessary, as well as unwanted, deviation from the original blueprint for the health service. "When the act was introduced the Minister of Health stated that, within certain limits, regional hospital boards and hospital management committees would be given full authority to manage their own affairs, but it has not worked out so in practice," an editorial in the magazine *Hospital and Health Management* said indignantly not long ago. "More and more the Ministry and, in turn, regional hospital boards, have interfered with the actual management of the hospitals."

The same charge, more or less, was given Parliamentary dignity during the health service debate when Labor Member A. Blenkinsop, formerly Parliamentary Secretary to the Minister of Health, said there were "a multitude of economical and valuable schemes which would undoubtedly save the hospital authorities money if they were able to put them into force, but which they are not able to put into force because of the attitude that the Minister is adopting."

This view was not without support on the other side of the House. Col. Stoddard-Scott, for example, the man who acknowledged that the health service is popular, effective and permanent, described the regional hospital boards as "post offices between the hospital management committees and the Min-

(Continued on Page 138)

Hill-Burton Is Passing the Test of Time

A few have misgivings, but most hospital and medical authorities think H-B is doing the job

TO THOSE who know it best, Hill-Burton is a nonpolitical program under which public and private groups have joined forces in a reasonable effort to improve the nation's medical care—an objective which has been achieved. The program should be carried forward for at least five years and with at least as much money as has been spent so far, but with special emphasis now on facilities for chronic disease.

This was the consensus of a group of 54 hospital and public health administrators, medical executives and practicing physicians whose views on the subject were sought in a MODERN HOSPITAL opinion poll. As a study of the replies on the following pages will reveal, however, this evaluation of Hill-Burton was by no means unanimous, and many of its most enthusiastic advocates have reservations about the extent to which states and communities should lean on federal aid for hospital construction. Few if any of the respondents want federal subsidies for anything but construction. Most of them rejected a suggestion that federal grants might be contingent on adequate local arrangements for indigent payments; desperately needed as such arrangements are, they felt, this is the community's business, and not the government's.

Similar caution was displayed in response to a question on licensing. All but a handful think hospital licensing is needed to protect the public against substandard operations, but a substantial number do not want licensing laws to include standards for medical staff organization. This is the province of voluntary effort, they believe, and they are well satisfied that the Joint Commission on Hospital Accreditation can do the job.

Because the replies were too discursive, one question is not included in the summary: "Do you believe Hill-Burton is a step toward socialism?" Six of 54 respondents think it is. "We have seen the gradual increase of government regulation through government subsidy," said one administrator, "yet we seem unable to recognize the insidiousness of this trend. At the rate we have been going, complete domination by government will occur within another generation."

The rest of the group take a more relaxed view of the subject. Alert to the hazards of long-continued subsidy and dependence on federal aid, they think Hill-Burton has successfully avoided the danger and represents a reasonable basis for cooperative effort by public and private agencies, with adequate safeguards against creeping dependency. "Actually, it is a step away from socialism," one administrator said, "because the Act was written to prevent government control or intervention. Instead, it has strengthened voluntary, local control of hospital care."

For details of how this happy result has been accomplished, turn the page.



GEORGE F. LULL, M.D.
Sec'y, American Medical Assn.



RAY E. BROWN
Administrator, III.



PAUL R. HAWLEY, M.D.
A.C.S. Director, III.

1. Has Hill-Burton been a success? Why?	Yes. Has helped to furnish needed beds, especially in rural areas.	Yes. Impetus for expansion of beds and better distribution of beds.	Qualified success. Hospitals are not buildings.
2. Has construction of H-B hospitals changed quality of medical care in U.S.? How?	Yes. With modern diagnostic equipment available to physicians, better medical treatment ensues.	Not too much. Effect has been on quantity more than quality. Some effect on quality through easier access to diagnostic facilities for doctors.	Not significantly. Many H-B hospitals built where training of medical men is inadequate for major surgery.
3. Should government carry larger share of construction cost? Of hospital care cost?	No. Government participation in general hospital care should be limited to persons in the indigent classification.	No would encourage over-building.	No.
4. Has influence of politics been observable in operation of Hill-Burton?	Influence of local or state politics has not come to my attention, though there are rumors of jealousy.	No.	No.
5. Have state hospital advisory committees been active?	Yes, but in some states advisory groups have not been able to accomplish much.	Yes.	Don't know.
6. Have authorities insisted on adequate evidence that owners can finance hospital operation?	Yes.	In general yes, but there have been exceptions.	No. Frequently hear of communities unable to finance operation of new hospitals.
7. Are construction regulations reasonable?	Should be more flexible.	Somewhat severe.	Don't know.
8. Is bed-population formula of H-B reasonable?	Too high for general hospital beds; TB standard seems excessive.	Too many general and mental, too few chronic. Depends on local conditions.	No opinion.
9. Should Hill-Burton be continued? How long? What should annual federal contribution be?	Yes, until hospital requirements of needy areas are reasonably fulfilled. Federal contribution of \$75 million.	Indefinitely because federal taxing power is greater. \$100 million annual federal contribution.	Only until states and local communities sufficiently stimulated to carry on and expand program.
10. Should law include mandatory provision ensuring adequate payments to hospital for indigent care by city, county and state welfare authorities?	No. Would be step toward further federal encroachment on local prerogatives.	No. Would preclude participation by voluntary hospitals in many areas.	By all means. Public should insist indigents receive same quality care as paid patients, and must expect to pay the cost of such care.
11. Should more H-B money be spent for chronic facilities? Mental? TB?	More for chronic. More for mental, but not by federal government.	More chronic and TB hospitals, more mental facilities in general hospitals.	More chronic facilities.
12. Should state advisory groups have veto powers, like Federal Hospital Council?	No answer.	Would assure nonpolitical control. Have not seen evidence that this is needed yet, however.	Yes, as protection against influence of politics.
13. Is hospital licensing desirable? Should licensing laws include standards for medical staff organization?	Yes, but features pertaining to medical staff organization, can best be evaluated by voluntary accrediting agencies.	Yes. Not for staff standards, though.	Yes. Laws should include staff organization standards.



E. J. McCORMICK, M.D.
Surgeon, President, A.M.A.



IRENE F. McCABE
Hosp. Assn. Sec'y, Mo.



CARROLL McCRARY
Administrator, Tex.



R. B. ROBBINS, M.D.
Pres., Amer. Acad. G.P.

Yes. Has placed hospital facilities in towns not otherwise able to build.

No. Great danger in building many small hospitals is trained personnel supply—danger of lowering quality of medical care if staff is inadequate.

No. Government care should be limited to indigents.

Yes, there have been abuses. Great efforts to secure funds politically in one or two instances.

Yes, in my state.

Flexibility is necessary.

General beds high.

Doubt in my mind about actual need. I understand there have been excess funds and that requirements have been cared for. \$75 million.

Yes, but with safeguards against government control.

Actual need for chronic facilities, but TB is on decline.

Yes, unless the state agency uses good judgment in its recommendations.

Yes, for protection of patients against fire, etc., but definitely not including staff organization standards.

Yes, but should stop now and study. Need to put first things first, such as staffing.

In limited way, by attracting better trained men to some communities. Not true in every instance.

No. Would encourage attitude that Great White Father's coffers are limitless.

Only in appointments.

Yes.

Yes.

Too few general beds for large cities.

Results should be reviewed to determine if beds under construction can be staffed and communities can support hospitals. \$75 million.

Should be mandatory for all hospitals, not just H-B.

More chronic.

Too much danger of serving selfish interests.

Yes. Inclusion of medical standards would be real protection for public.

I have been opposed to H-B. It's a step toward socialism. protection.

Definitely improved in some isolated instances, but the same thing could have been done with local money at less expense to U.S. taxpayers.

No. At rate we have been going for 20 years, complete domination of government will follow.

No. It has been unusually clean up to this point.

Members of committee have been opposed to H-B; therefore one could not expect much cooperation from them.

Fair job, but some cases not adequately prepared financially.

Too severe for small community hospitals. Does not seem to be reason for many frills

General hospital figure too high for the Southwest.

No. Feeling is based on strong dislike of government intervention. Why can't we stand on our own feet?

No. Local hospitals should refuse to build until local authorities have signed indigent contract. Federal regulation would bring about government control.

We can do it without H-B.

Yes. Veto power would nullify political pressure. Intention of Act is to help hospitals that need help most.

Yes. Without licensing anything can be classified as a hospital and public has no protection.

Yes, in general. However some instances hospitals b where they weren't nee

Yes, quality of care has b improved in many areas.

No.

No.

Yes.

Not too carefully.

Yes.

Yes.

Yes, for several years, at \$ million a year federal c tribution.

No. This would be fed dictation.

Don't know.

No.

Yes, there must be so means of maintaining sta ards, including standards medical staff organization.



E. J. McCORMICK, M.D.
Surgeon, President, A.M.A.



IRENE F. McCABE
Hosp. Assn. Sec'y, Mo.



CARROLL McCRARY
Administrator, Tex.



R. B. ROBBINS, M.D.
Pres., Amer. Acad. G. I. and P. S. C.

Yes. Has placed hospital facilities in towns not otherwise able to build.	Yes, but should stop now and study. Need to put first things first, such as staffing.	I have been opposed to H-B. It's a step toward socialism. protection.	Yes, in general. However some instances hospitals have improved where they weren't needed.
No. Great danger in building many small hospitals is trained personnel supply—danger of lowering quality of medical care if staff is inadequate.	In limited way, by attracting better trained men to some communities. Not true in every instance.	Definitely improved in some isolated instances, but the same thing could have been done with local money at less expense to U.S. taxpayers.	Yes, quality of care has been improved in many areas.
No. Government care should be limited to indigents.	No. Would encourage attitude that Great White Father's coffers are limitless.	No. At rate we have been going for 20 years, complete domination of government will follow.	No.
Yes, there have been abuses. Great efforts to secure funds politically in one or two instances.	Only in appointments.	No. It has been unusually clean up to this point.	No.
Yes, in my state.	Yes.	Members of committee have been opposed to H-B; therefore one could not expect much cooperation from them.	Yes.
No.	Yes.	Fair job, but some cases not adequately prepared financially.	Not too carefully.
Flexibility is necessary.	Yes.	Too severe for small community hospitals. Does not seem to be reason for many frills.	Yes.
General beds high.	Too few general beds for large cities.	General hospital figure too high for the Southwest.	Yes.
Doubt in my mind about actual need. I understand there have been excess funds and that requirements have been cared for. \$75 million.	Results should be reviewed to determine if beds under construction can be staffed and communities can support hospitals. \$75 million.	No. Feeling is based on strong dislike of government intervention. Why can't we stand on our own feet?	Yes, for several years, at \$ million a year federal contribution.
Yes, but with safeguards against government control.	Should be mandatory for all hospitals, not just H-B.	Local hospitals should refuse to build until local authorities have signed indigent contract. Federal regulation would bring about government control.	No. This would be federal dictation.
Actual need for chronic facilities, but TB is on decline.	More chronic.	We can do it without H-B.	Don't know.
Yes, unless the state agency uses good judgment in its recommendations.	Too much danger of serving selfish interests.	Yes. Veto power would nullify political pressure. Intention of Act is to help hospitals that need help most.	No.
Yes, for protection of patients against fire, etc., but definitely not including staff organization standards.	Yes. Inclusion of medical standards would be real protection for public.	Yes. Without licensing anything can be classified as a hospital and public has no protection.	Yes, there must be some means of maintaining standards, including standards for medical staff organization.



S, M.D.
cad. G.P.



J. P. RICHARDSON
Administrator, N.C.



EVARTS A. GRAHAM, M.D.
Surgeon, Mo.



DAVID LITTAUER, M.D.
Administrator, Mo.



L. E. RICHWAGEN
Administrator, Vt.

However, in
hospitals built
n't needed

re has been
y areas.

Yes. Supplied impetus for
planned construction program.
Has been fair, impartial.

Not sure. Unnecessary and
bad surgery often performed
in these hospitals.

Yes. Has increased available
beds where needed, released
local funds for renovation.

Yes. Local planning, sponsor-
ship and support keep costs
down.

Yes. Care improved by avail-
ability of beds, diagnostic
facilities.

Hospitals not numerous
enough to have changed over-
all quality of medical care.

Yes. More adequate facilities
will eventually have impact
on quality of medical care.

Yes, by providing modern
workshops and attracting
qualified doctors to rural
areas.

No, except local aid for in-
dignants. Public pays cost of
hospitalization, either through
taxes or contributions.

No.

No, except for indigents.

No. Possibly federal contribu-
tions to states for indigent
care.

No. Act has been fairly ad-
ministered in our state.

No.

No.

Not bad.

Advisory council interested
but has had few opportunities
to be active.

Yes.

Yes, most conscientious.

No.

Yes.

Don't know.

Yes.

Yes.

Yes.

Don't know.

Yes.

Yes.

Should be flexible enough to
accommodate local conditions.

Yes.

Too few general beds.

About right.

ars, at \$75
ederal con-
-

Yes. Will take 5 more years
to complete job. Federal con-
tribution should be \$100 mil-
lion annually.

Yes, for 10 years, which
should be enough to deter-
mine whether or not it is
a good idea. \$100 million a
year federal contribution.

Five more years. Still far
from saturation, and more
beds become obsolete every
year. Federal contribution
should be \$150 million.

Yes, with reevaluation of
need and probably more em-
phasis on modernization, men-
tal, TB and chronic beds in
general hospitals.

be federal

e federal

Yes. Government should not
make people assume obliga-
tions, but this is probably
only way to bring order out
of present hodgepodge of in-
digent payments.

Yes.

No. Should be in different
law, not construction pro-
gram.

No. This should be worked
on separately, not included
in H-B.

More chronic and mental; TB
questionable. Should be re-
lated to general hospitals as
far as possible.

Yes.

Yes, for chronic and mental,
but not TB. Definitions of
chronic and mental care
should be clearer.

Yes.

No. Should be advisory only.
Have neither time nor knowl-
edge for direct responsibility.

Depends on how advisory
groups are selected. Could be
either useful or harmful.

No, but should be ample pro-
vision for consideration of
dissenting views.

Don't know.

be some
ng stand-
ards for
ation.

Yes. Public has right to know
standards are acceptable. Medi-
cal standards desirable.

Yes. It is outrageous to fail
to protect the public. Should
include medical staff stand-
ards.

Indicated for greatest good
of greatest number. Stand-
ards relating to medicine
should not be included.

Yes, but medical staff stand-
ards should be left to Joint
Commission.



MSGR. GEORGE L. SMITH
Diocesan Hosp. Dir., S.C.



VERNE A. PANGBORN
State Health Dept., Neb.



A. W. SNOKE, M.D.
Administrator, Conn.



JAMES W. GRAHAM, M.D.
General Practitioner, Mo.

Yes, has stimulated construction needed facilities. Little federal dictatorship.

Indirectly, by providing facilities where they were lacking.

No. Not if it is possible to finance care through other means, especially voluntary prepayment.

To some extent. Special priority established for one institution, depriving needy areas of state of substantial aid.

Yes.

Yes, but some of smaller hospitals are heavy burden to maintain.

Yes.

Too many general beds; too few chronic.

Yes, for 5 years. Have not yet met urgent needs in many areas. \$75 million federal contribution.

No, this state and county problem.

More chronic.

Definitely. Service in rural areas transformed, modernized.

Improved, especially in rural areas, by attracting qualified professional people.

Present program effective. Any attempt to inject assistance for hospital care would make it socialistic.

No. Such political efforts as were put forth were non-productive.

Yes. Great strength to program.

Yes. Any further supervision of finances would lead to supervision of operations, which is repugnant.

Yes. Good guide to design.

Yes. Formula should be considered ceiling, not desirable ratio for all areas.

Should be continued until all major needs are met, by periodic extensions. \$75 million appears to be satisfactory compromise.

This would open door from construction to operation. Indigent care must remain responsibility of local area.

Up to states.

Yes. Stimulated construction and regional planning, improved design.

Hard to tell. Obviously, where hospitals did not exist or were inadequate new construction provided facilities where doctors can give better care.

Depends on local resources and local necessity. Care should be financed at cost for government patients.

None.

Not in this state.

Don't know.

Yes.

Yes.

Yes.

Yes.

Government should pay cost, but local circumstances may be such that mandatory agreements not required.

Yes.

Yes, for five years, with government share between \$75 and \$150 million.

Should be continued until bed shortage is relieved. \$75 million federal contribution.

Yes, to ensure adequate care of indigents.

Yes. Brings hospital facilities and beds to many in rural communities.

Yes. Care more efficient in modern facilities.

Regulation of hospital financing is needed. Most of money going to big hospitals with closed staffs.

Query: How do few hospitals get so much money for improvements?

Standards are high and should be high.

Too few beds.

No. States have too much authority already.

Yes.

Have not made up mind on this. If advisory board high class and public spirited it is an advantage.

Yes. Don't know about staff standards.

No need for change. Proper use of advisory council matter of good administration.

Yes, but professional standards should be left to voluntary accreditation agencies, not licensure.

Not if like Connecticut advisory group, which is too large, not well informed, represents special interests.

Yes. Hospitals can become sloppy and self-satisfied. Medical staff standards could be of value.

Yes. Public has absolutely nothing to say now. Staffs should be open, as courts are open to all attorneys.



THOMAS HALE Jr., M.D.
Administrator, N.Y.



HORACE TURNER
Administrator, Wash.



HARVEY H. WEISS
Administrator, Md.



CHARLES W. FLYNN
Hosp. Assn. Sec'y, Miss.

Yes, in helping hospitals with building programs not otherwise possible.

Yes. Better facilities and, in rural areas, better doctors attracted to communities.

Government should carry larger share of construction cost and pay hospitals full cost for indigent.

No.

Only in small communities.

Has helped many small towns secure adequate hospitals.

Yes and no. Danger of doctors attempting work beyond their ability in order to keep patient in local hospital.

Yes. Has raised hospital standards physically and medically, helped get larger and smaller hospitals to cooperate in regional programs.

Yes. More and better hospitals. Has developed community pride.

Yes, by giving doctors better facilities, bringing specialists in contact with country doctors, and stimulating interest in education.

Very.

Yes.

Yes.

State agency does job.

No evidence to the contrary.

We will see closing of many small hospitals for lack of funds and patronage.

Yes.

In most cases, yes. Two hospitals here had insufficient capital.

Yes.

Too much interference by federal office.

Yes.

No opinion.

As long as we have to have arbitrary standards, yes.

Too many general beds.

Too few mental and chronic beds.

About right for general hospitals. Too few TB beds.

Yes, needed as long as there are areas where construction is indicated. \$75 million a year federal contribution.

Yes, as long as there is need. \$100 million a year federal contribution.

Yes, until standard for beds in all categories is achieved. \$75 million would assure steady progress.

Yes, indefinitely. \$150 million should be minimum federal contribution, until adequate number of acceptable beds.

No. Should be left to local agreements.

Yes. Patients should not have to carry load in form of higher rates.

No. This should be attained by local negotiation.

Yes. Hospital should be willing to do its share by complying with uniform accounting system.

Not in position to judge, but need for TB beds should be restudied.

Yes.

More chronic and TB facilities. Mental should remain function of state and local communities.

No. General hospitals should provide care for all types of cases.

Don't know.

Yes. Helps give better service to public.

This is done in Maryland.

No. Too many cooks spoil soup.

Yes, but states should not get into staff organization. This would duplicate work of Joint Commission.

Yes. Fully accredited hospitals should be exempt, staff standards should not be included in licensing law.

Yes. Should be standards for staff organization, either by law or by state medical society.

Absolutely, but not including staff standards. Voluntary standards better.



TOL TERRELL
Administrator, Tex.



JESSE H. BANKSTON
Hosp. Assn. Sec'y, La.



JOHN J. BOURKE, M.D.
State Hosp. Comm., N.Y.

1. Has Hill-Burton been a success? Why?	Yes. Improved facilities and helped decrease acute bed shortage.	One of most successful grant-in-aid programs. Flexibility of administration notable.	Yes. Stimulated interest better service, better planning, better distribution.
2. Has construction of H-B hospitals changed quality of medical care in U.S.? How?	Good and bad. More hospitals mean trained personnel spread too thin, and situation is getting worse.	Vastly improved, by provision of functional facilities.	Yes. Better diagnostic and therapeutic equipment for rural and small urban communities, better working relationship between hospitals.
3. Should government carry larger share of construction cost? Of hospital care cost?	No.	No. If a community cannot support a hospital it should not be built.	No. But government should pay cost for indigents.
4. Has influence of politics been observable in operation of Hill-Burton?	Yes. State institutions seem to have first claim on money.	No. Differences of opinion about location of hospitals, etc., have been policy, not political, differences.	Not in N.Y. Representative regional councils tend to discourage political influence.
5. Have state hospital advisory committees been active?	Yes.	Advisory council active and helpful at first, now regrettably inactive in Louisiana.	Decidedly.
6. Have authorities insisted on adequate evidence that owners can finance hospital operation?	No.	Yes.	Yes. State standards higher than law requires.
7. Are construction regulations reasonable?	Don't know.	Yes.	Yes.
8. Is bed-population formula of H-B reasonable?	Too many general beds for this part of country.	Too many TB beds.	Reasonable in beginning. However, more research and experimentation needed.
9. Should Hill-Burton be continued? How long? What should annual federal contribution be?	Yes, but changed so that money is spent first to train staff for hospitals already built. \$75 million federal contribution.	Should be permanent, to assure replacement and meeting of long-term needs. Federal contribution of \$150 million a year.	Yes. Present program not keeping up with yearly increment of bed needs. Careful research and experimentation needed to avoid overbuilding.
10. Should law include mandatory provision ensuring adequate payments to hospital for indigent care by city, county and state welfare authorities?	Yes, so all taxpayers would share equally in care of indigent.	No. This is local concern.	No. Should be worked out on voluntary, cooperative basis in states and communities.
11. Should more H-B money be spent for chronic facilities? Mental? TB?	No. Should be state responsibility.	Not in Louisiana. Need here is for more community hospitals.	More chronic and mental. That is questionable.
12. Should state advisory groups have veto powers, like Federal Hospital Council?	Yes.	Yes.	No. Properly constituted advisory council can work cooperatively with responsible government agency.
13. Is hospital licensing desirable? Should licensing laws include standards for medical staff organization?	Yes, so public can know what to expect of hospital, but not covering staff organization.	Yes. Licensing law should make it possible for staff standards to be established, but these should not be law.	Yes, but strongly flavored with educational approach. Need for program of medical audits.



, M.D.
, N.Y.



J. HAROLD JOHNSTON
Hosp. Assn. Sec'y, N. J.



PETER B. TERENZIO
Administrator, S.C.



JANE BOYD THOMAS
Administrator, Pa.



MOODY MOORE
State Health Dept., Ark.

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medical

Yes. Has assisted communities in providing good quality facilities.

Yes. Improved by stimulus to better work, and greater educational opportunities.

No, except locally for indigent care.

None whatsoever in New Jersey.

Very much so.

Yes, in New Jersey.

Yes.

No answer.

Yes, until need is met. Might be discontinued state by state as agreed percentage of bed needs, including replacement, is met.

No. Arrangements vary so widely from state to state that this would not be workable.

More for chronic but not mental and TB in New Jersey.

Desirable as curb on bureaucracy.

Yes, but not staff standards.

Yes, but we have built too many small (25 bed) hospitals.

Yes. More and more people know about accreditation. More communities attracting physicians where they had none.

No. Government must never carry more than a share (less than 50 per cent) of total burden.

No. Politicians afraid to touch anything public is so vitally interested in.

Yes.

No.

Yes.

Yes. Too many mental beds if more were put into general hospitals.

Yes, until most needs are met. \$100 million.

Yes. Under taxation, everyone would share in charity hospitalization.

Yes. We are getting pretty well fixed with general beds.

Don't know.

Yes. Average staff not prepared to accept anything but voluntary inspection of professional matters at this time.

Yes. Many communities now have facilities the community could not provide.

Yes. Better facilities attract better physicians. This is not hearsay; I have experienced this fact.

No. Every community wants to shoulder its responsibilities. Too much help would choke initiative and pride.

No. As chairman of one regional advisory committee and a member of another, I have seen no evidence.

Yes.

Unbelievable minimum.

Yes.

Yes. Restudy and modernization should be attempted now.

Yes.

Yes. Where community is willing to carry reasonable share of expense it should be helped.

Yes. Clear, written understanding of policy will do away with future misunderstandings.

If so, the word "advisory" should be removed.

Inspection definitely desirable. Why shouldn't licensing laws include staff standards?

Yes.

Yes. Preventive of socialized medicine.

Definitely. Hospitals with adequate facilities have eliminated countless small proprietary units.

No.

Unbelievable minimum.

Yes. Only one institution in state has had financial difficulty, and there are many factors involved in this case.

Yes. Restudy and modernization should be attempted now.

Too many general and mental, too few TB.

Indefinitely. Less than one-fourth of goal has been achieved. \$150 million for 2 years to clear backlog.

Yes.

Mental and TB adequate. Don't know about chronic.

Yes.

Yes, including staff standards. State agencies should cooperate closely with Joint Commission.



RICHARD T. VIGUERS
Administrator, Mass.



ALLAN BARTH
Hosp. Assn. Sec'y, Mich.



MARGARET DUBOIS, M.D.
State Health Dept., Conn.



DONALD W. CORDES
Administrator, Iowa

Of course; has assisted local groups to obtain necessary facilities for medical care.

Yes. Facilities for improved care. Also creates centers of medical and public education and community organization.

Maybe in some situations for construction but not, as a general principle, for hospital care.

As far as I know, none.

Yes.

Yes, as far as I have observed.

Yes.

Yes.

Continue until we approach goal established in state surveys. New surveys should be undertaken in about four years. Need \$150 million.

No. Should be left to local area for decision.

Depends on local survey.

No opinion.

Necessary to ensure minimum standards.

Yes. Meeting otherwise neglected need.

Yes. Stimulated better practice of medicine, better personnel, over-all care.

More for construction, not for care.

Yes. Program diluted more and more with persons not qualified in hospital administration.

Interested but not adequately utilized.

Yes.

Yes.

Yes.

Yes, for four years, to meet need for facilities. Act should include funds for auxiliary service facilities where beds are not needed.

Would be nice, but could lead to abuse. State and local rights should be preserved.

No. This state responsibility.

Depends on makeup of state agency and advisory group. If agency is political and advisory council professional, yes.

Yes, if licensing board is composed predominantly of hospital administrators. Should not include medical staff.

Yes. Has stimulated construction and made public aware of need for beds.

To some extent, by leading to licensure laws and minimum standards.

No. Cost of care should be local problem.

No.

Varies with states. Some groups too large to be active.

Yes, but should include provision for simpler type of chronic disease hospital.

All right for general and TB hospital, too few mental and chronic beds.

Yes, if it is to accomplish original purpose. Present appropriations barely maintain existing ratio of beds to population. Need \$150 million.

No. This should be settled within state or community.

Greatest need is for chronic and mental facilities.

No, because many council members not familiar with hospital problems.

Yes, but educational rather than punitive. No medical standards should be included in laws.

Great success. Has put hospitals where needed, improved architectural standards.

Possibly, by attracting physicians to new rural hospitals. But chief contribution has been to other aspects.

No.

Not in our state. Have heard of a few instances of interference elsewhere.

Yes, but some advisory councils have been antagonistic to state authorities.

No. This is major criticism of administration of act. Should be strengthened.

Very good.

All right nationally but may be wrong for state or local populations.

Should be continued indefinitely for communities unable to obtain construction funds otherwise, but may become crutch for some.

No. This is administrative responsibility which alert board and qualified administrator should work out.

More for chronic and mental, but not TB. Difficulty here is continued financing.

No. But state agencies should pay more attention to advice of councils. Some states have been independent.

Yes. "Mild police power" seems to be only way to get some hospitals to raise standards.



CHARLES M. ROYLE
Hosp. Assn. Sec'y, N.Y.



GEORGE K. HENDRIX
Public Health Dept., Ill.



H. G. FRITZ
State Health Dept., Md.



ANDREW PATTULLO
Foundation Executive, Mich.

Yes. Has stimulated local action to get needed facilities, improved design.	Tremendous success: Hospitals in areas never before served; facilities improved.	Yes. Has given needed hospitals to rural areas, added beds and adjunct facilities.	Yes. One of most significant developments in hospital field since 1900.
Not necessarily, but is one more influence in changing medical pattern.	Probably, through greater utilization of better facilities.	Yes. Good planning and equipment contribute to high standards.	Absolutely, by attracting physicians to rural areas.
No, but all government agencies should pay full cost for indigents.	No.	Present federal participation satisfactory.	No, except for indigent care.
Not in New York State, although some have made effort.	Political pressure has been applied but state agency has not yielded to pressure. This is notable feature of H-B.	No. One hospital president said, "This formula doesn't give a politician a chance."	Surprisingly little in administration of act. Have been some questionable political appointments.
Most helpful, even beyond provisions of program.	Yes. Use of advisory group up to state agency.	Yes.	Helpful, but not used as much as could be.
Yes. One or two cases of unforeseen difficulty.	No. Neither states nor P.H.S. have insisted on adequate evidence.	Yes. More detailed study would produce more information on hospital's ability to meet deficits.	Yes.
Yes. Have intelligent flexibility.	Yes. Can't imagine anyone wanting to build a hospital with lower standards.	Yes.	Yes.
Formula could easily become obsolete. Should be experimentation.	Sound for U.S., but should be possible for states to deviate.	About right. TB formula should be restudied.	Probably, as general guide.
Five years, with provision for further renewal. \$150 million federal contribution.	Five years should be adequate. Time must come for communities to face own responsibilities; \$150 million a year for 5 years.	Should continue until hospitals are reasonably adequate in all categories. \$75 million minimum appropriation, raised to \$150 million.	Act has largely met original objective of providing rural hospitals. Limited extension should be based solely on demonstrated need.
No. Would lead to restrictive applications. Could do disservice to hospitals and people they serve.	This not a matter of legislation.	No mandatory agreements necessary if hospital fulfills obligation to community and state and local governments provide reasonable contributions.	Worth serious consideration.
More for chronic as general needs are fulfilled.	For states to decide. Some have maintained proper balance, others concentrated on general hospitals.	Law should allow higher federal participation to encourage provision of chronic and mental facilities.	No. Favor restricted grants for pilot projects. Folly to perpetuate present pattern of hospitalization for chronic.
No. Should be intelligent cooperation, but veto powers would not be in best interest of public.	See no need for veto power. Prefer true advisory function.	No need for veto power. State board here has approved every recommendation of advisory council.	No. State councils not same caliber as national council. Advice usually heeded anyway.
Yes. Official means of upholding standards, eliminating bad institutions. Should include staff standards.	Yes, with major emphasis on service rather than policing. Should not include medical staff standards.	Yes.	Absolutely. Licensing immensely valuable in upgrading care. Medical standards should be included.



GEORGE F. LULL, M.D.
Sec'y, American Medical Assn.



RAY E. BROWN
Administrator, III.



PAUL R. HAWLEY, M.D.
A.C.S. Director, III.

1. Has Hill-Burton been a success? Why?	Yes. Has helped to furnish needed beds, especially in rural areas.	Yes. Impetus for expansion of beds and better distribution of beds.	Qualified success. Hospitals are not buildings.
2. Has construction of H-B hospitals changed quality of medical care in U.S.? How?	Yes. With modern diagnostic equipment available to physicians, better medical treatment ensues.	Not too much. Effect has been on quantity more than quality. Some effect on quality through easier access to diagnostic facilities for doctors.	Not significantly. Many H-B hospitals built where training of medical men is inadequate for major surgery.
3. Should government carry larger share of construction cost? Of hospital care cost?	No. Government participation in general hospital care should be limited to persons in the indigent classification.	No, would encourage over-building.	No.
4. Has influence of politics been observable in operation of Hill-Burton?	Influence of local or state politics has not come to my attention, though there are rumors of jealousy.	No.	No.
5. Have state hospital advisory committees been active?	Yes, but in some states advisory groups have not been able to accomplish much.	Yes.	Don't know.
6. Have authorities insisted on adequate evidence that owners can finance hospital operation?	Yes.	In general yes, but there have been exceptions.	No. Frequently hear of communities unable to finance operation of new hospitals.
7. Are construction regulations reasonable?	Should be more flexible.	Somewhat severe.	Don't know.
8. Is bed-population formula of H-B reasonable?	Too high for general hospital beds; TB standard seems excessive.	Too many general and mental, too few chronic. Depends on local conditions.	No opinion.
9. Should Hill-Burton be continued? How long? What should annual federal contribution be?	Yes, until hospital requirements of needy areas are reasonably fulfilled. Federal contribution of \$75 million.	Indefinitely because federal taxing power is greater. \$100 million annual federal contribution.	Only until states and local communities sufficiently stimulated to carry on and expand program.
10. Should law include mandatory provision ensuring adequate payments to hospital for indigent care by city, county and state welfare authorities?	No. Would be step toward further federal encroachment on local prerogatives.	No. Would preclude participation by voluntary hospitals in many areas.	By all means. Public should insist indigents receive same quality care as paid patients, and must expect to pay the cost of such care.
11. Should more H-B money be spent for chronic facilities? Mental? TB?	More for chronic. More for mental, but not by federal government.	More chronic and TB hospitals, more mental facilities in general hospitals.	More chronic facilities.
12. Should state advisory groups have veto powers, like Federal Hospital Council?	No answer.	Would assure nonpolitical control. Have not seen evidence that this is needed yet, however.	Yes, as protection against influence of politics.
13. Is hospital licensing desirable? Should licensing laws include standards for medical staff organization?	Yes, but features pertaining to medical staff organization, can best be evaluated by voluntary accrediting agencies.	Yes. Not for staff standards, though.	Yes. Laws should include staff organization standards.



MARVIN ALTMAN
Administrator, Ark.



HERBERT A. ANDERSON
Administrator, Neb.



CHARLES S. BILLINGS
Hosp. Assn. Sec'y, Kan.



PAT N. GROENER
Administrator, Fla.

Tremendous success in spite of flaws. Outstanding feature is lack of federal control.	Qualified success. Has replaced some poor facilities and improved design.	Yes, but some communities have built small hospitals when they needed only clinics.	Unquestionably the best federal money ever appropriated.
Too soon to tell. Good buildings and equipment do not make a good hospital.	Yes. Improved facilities lead to better care. Rural hospitals have encouraged some M.D.'s to attempt procedures beyond their training and ability.	Yes. Over-all standards of care have been raised.	Yes. Improved facilities, along with other factors, have contributed to higher quality care.
No. We need to keep federal help at minimum. If we abandon this philosophy we invite trouble.	H-B is mild form of socialism. Community care should be responsibility of community.	Yes.	No. Should not exceed one-third.
Yes. Some hospitals have been built for reasons other than need.	Yes. Location of hospitals has been determined by political influence of U.S. senators, state senators, and others.	Not to any extent in our state.	Not greatly.
This is biggest weakness of H-B in some states. Some committees active in developing plans.	Active, but often misinformed on hospital matters.	Yes.	Yes.
No.	Definitely not. Many hospitals built in state without adequate thought to personnel and money needed.	Yes.	No. Many have been in financial trouble, though poor administration is the primary cause.
Yes.	Yes.	Yes.	Yes.
Too few mental and chronic beds.	No. Provides too many general beds, not enough chronic.	Adequate but not flexible enough for needs of local community.	More consideration should be given other factors, such as occupancy, population trends.
Yes, for 10 years, until old, obsolete buildings are remodeled or replaced. \$100 million a year federal funds.	Yes, but not until federal budget is balanced. Will take many years to meet all bed needs. Federal contribution should be restudied.	Yes, until bed needs are met.	Don't know.
Yes, would help hospitals.	No. Mandatory provision would make it more and more difficult to certify patients as entitled to care.	Yes, as far as possible to make agreements that will meet need.	Yes, but what is adequate? Many of us want full payment where efficient service is not provided.
Yes.	More chronic, perhaps more mental, but not TB.	Yes.	Yes.
Yes. Without this control, state agencies tend to become bureaucratic.	Yes, if group is strong and has adequate representation from active hospital field.	No. Problems should be resolved jointly.	Not answered.
Yes, including medical staff standards.	Yes. Tends to elevate standards in long run. Should not include medical staff standards. Joint Commission can do.	Yes, but staff standards should be flexible enough to suit local conditions.	Yes, too many institutions have no desire to maintain standards. Licensing should include standards of staff.

Employes' Conference Is the Safety Valve

that keeps small grievances from becoming big ones

JOHN FRENCH ALLEN

San Francisco

ORDERLY Lou Brooks tugged at the door to the third floor north soiled linen chute and felt anger rising inside him as once again it refused to budge. He dropped his bundle, pulled with both hands against the too-tight spring. It was a routine that had been going on for months. Brooks knew he should not let anger stir him, sensed he should tell someone about the door. Yet it always seemed such a minor matter, hardly worth an administrator's time.

Mary Marks of the hospital kitchen staff walked out of the oven-warmed room into the drafty corridor to punch the time clock. Every time she made the trip she reminded herself that she was "very susceptible to colds." It was a frustrating nuisance, but there seemed no remedy.

Mrs. Margaret Fraser of the x-ray

department was annoyed. Again a patient had arrived for second procedure fluoroscopy with a stomach full of food. Didn't anyone read the orders? And now the patient was mad at her—because it meant the expense and bother of another day in the hospital. She knew if she complained to every individual floor nurse it would only make her enemies. She sighed and forgot her troubles for the moment.

Eleanor Montgomery of the tray department was also annoyed—by wooden door stops, of all things. She would stop a door with the wedge-shaped bit of wood and then watch it slowly creep closed as she approached with her trays. She was sure rubber stops would be the answer, but no one seemed interested.

There was hardly a nurse on any floor who wasn't mad at the casual and

messy window washer. He seemed to have an almost deliberate knack of stepping through a window into the room of a woman patient at the worst possible time. He left window ledge puddles wherever he went. Yet no one liked to complain.

It had never seemed fair to Orderly Floyd Clardy that nurse's aides were permitted to have their uniforms laundered by the hospital, while orderlies had to see to their own. It was a sore point with Clardy's fellows, too, but no one of them wanted to stick his neck out far enough to make an official complaint.

These are just six out of scores of annoyances which plagued the staff of St. Francis Memorial Hospital, San Francisco, through the early months of 1952. Petty annoyances. Taken alone, each one seemed hardly worth a moment's thought or action.

Yet, taken together, they added up to a sometimes unhappy and even disgruntled staff. Such tiny abrasive annoyances in time can come to create a real personnel problem. These things Administrator Orville N. Booth knew well. He knew that such annoyances existed, although he perhaps could not have named a single specific one. The problem, as he saw it, was to get them out in the open where they could be explained away or cured.

St. Francis long has had an administrative council, made up of Mr. Booth and 10 of his departmental heads. Mr. Booth also organized a monthly meeting of subdepartmental supervisors some years ago, hoping thus to reach down closer to individual employees and their problems. The council, he realized, never came close.

Emil Brown, orderly, picks up his uniforms from the laundry.



Miss Montgomery learned what to do about wood door stops.



Neither, really, did the subdepartment group. "Nobody said anything," Mr. Booth says now. "They all just sat around and listened to me. It was a one-way street."

Then, last October, Mr. Booth conceived the idea of a real employees' conference, a group made up not of the heads of departments or subdepartments, but of actual representative employees. He hoped it would provide a safety valve for staff members and a means of bringing complaints out into the light of day. In essence, this was to combine a sort of mass psychiatrist's couch and a town hall meeting.

There seems little question that it has been a huge success. The employees themselves are enthusiastic about the monthly meetings, and at not a single session has one of the 29 subdepartments gone unrepresented.

Best of all, there's been action all along the line. Some gripes have been explained away; some have been recognized as just, and appropriate action taken. In any case, every man and woman employed by St. Francis now knows there's a place to sound off—a place where no one thinks a complaint is too small or necessarily lacks merit.

"I'm learning," Mr. Booth says. "A lot of these things should have been cleared up a long time ago. But, before the conference was organized there was just no way I could learn that most of these problems even existed."

Instances?

Well, they put a new and lighter spring on the third floor north soiled linen chute, and Orderly Lou Brooks is a happier and more contented man.

Mr. Booth has explained to Mary Marks that when present reconstruction work is completed her time clock will be moved from the drafty corridor to a warmer and more convenient spot. Mrs. Marks, still "very susceptible to colds," is happily awaiting the day.

Nurses throughout the hospital have been apprised by their representatives to the conference of Mrs. Fraser's fluoroscopy problem. They have promised to remember. Mrs. Fraser is happy to report that the patient arriving in x-ray with a full stomach is now a rarity.

Eleanor Montgomery has been schooled in the proper use of wooden door stops, after general assurances that the rubber type is vastly unpopular among her fellow workers. She's happy.

The messy window washer has been replaced.

Mr. Booth was surprised to learn



Warren Thomas, head porter, speaks his mind at the employees' conference, in which representatives of all departments are given a chance to talk.

that orderlies' uniforms were not laundered by the hospital. He issued the necessary orders and now Floyd Clardy and his fellows are more contented.

Administrator Booth attended the early conference meetings, but he has come finally to believe that the group will function more realistically and with less restraint if he stays away. He is satisfied that the conference has provided a first-rate employee safety valve, that in no other way could employees be brought to feel their essential stake in the success of the hospital's over-all public relations program. A contented and responsive employee, he knows, is a major prerequisite to a satisfied and loyal patient.

What do the employees themselves think?

"This is one of the best things that ever happened around here," one orderly says. "A guy goes around nursing a bunch of gripes till he gets sore at the world. And a guy doesn't feel like beefing all the time to his bosses. You get the name of a malcontent that way. This way you or a guy who's speaking for you can stand up in meeting and get things off your chest. Other people are doing the same thing, so you don't figure you're making small time beefs or that you're a chronic griper. We get a lot of things cleared up amongst ourselves, too—things that never get any further than the meeting."

The legitimacy and good sense of the system is seemingly apparent also to the representatives of the various hospital unions. At first, as Mr. Booth had feared, there were mutterings from some of the unions that the hospital was attempting to horn in on a basic union function. One union representa-

tive appeared and demanded to see the minutes of the first few conference meetings. He seemed satisfied that this was no anti-union management plot—and there have been no complaints from that source since.

The actual formation of the conference Mr. Booth left in the able hands of his full-time public relations director (here called community relations director), a bouncing, vibrant and hard-working young woman named Helen Jones. Her first move was to call together four old-time employees, women who knew and were known to most of their fellow workers. The hospital's 29 subdepartments were split among them, with each assigned to find her share of conference delegates.

The four were immediately enthusiastic over the idea and found they had little trouble in finding delegates—in fact, it was sometimes difficult to choose from among a number of candidates. The first meeting was held last November 13, with these subdepartments represented: anesthesia, nurses (one delegate from each of six floors), maternity, nursery, surgery, central supply, orderlies, floor clerks, bookkeeping, x-ray, admitting, physical therapy, business office, laboratory, medical records, dietitian, laundry, engineers, housekeeping, storeroom, bells and elevators, kitchen and tray, and telephone.

The first order of business was the election of two of the four founders to office: Hulda Travaille, a head nurse, as president, and Linda Marchioni, of medical records, as secretary.

The delegates heard from Mrs. Travaille a general outline of the conference's purpose, posed for a picture, and listened seriously to a brief talk by Mr.

Booth. Then the president, sensing smartly that action was the best possible means of launching the conference, started around the table, asking each delegate for complaints and suggestions. There were not many, but certainly enough to indicate that the conference was not destined to die aborning. It was at this first meeting that Orderly Floyd Clardy broached the seeming inconsistency in the matter of uniform washing, and Mrs. Fraser her complaint about the food-laden fluoroscopy patients.

EACH ONE IS HEARD

In the monthly meetings since, the same general procedure has been followed, with Mrs. Travaille carefully giving each delegate a chance to be heard. Few pass. Now they come laden with not only their own ideas but those of the employees they represent. Many of the smaller problems can be and are settled on the spot. As witness these two more or less typical items culled from the minutes of a recent meeting:

"Several complaints were made by nurses about the numbers on thermometers fading out and being very hard to read. Ralph Olson stated that new thermometers were being placed on the floors and in the future they could be compared with the old ones as to the difference in fading."

"Helen Shockites, representing the anesthesia department, asked for suggestions making nurses available for assisting with patients returning from surgery. This was discussed with the nurses present and a plan agreed upon."

The mechanics of communication between the conference and the hospital's management have been worked out on a trial and error basis. At the first couple of conference meetings, Mr. Booth and Mrs. Jones sat in with the delegates, answering questions and attempting to settle disputes and complaints on the spot. This plan was quickly dropped when it became apparent that the conference would function better in the absence of authority and that a good many of the problems presented did not permit of off-the-cuff settlement.

The next try was to use Mrs. Jones' community relations office as the connecting link between the conference and the administrator. Mrs. Jones, the minutes of the last conference meeting at hand, took care of such minor items as she was able, while the rest were sent along to the administrator. Mr. Booth, in turn, acted upon those items

which seemed to him reasonable, and then dictated a report of accomplishment, denial and explanation, to be read at the following conference meeting.

The disadvantage of this plan quickly became evident: It loaded too much on the shoulders of Mr. Booth and Mrs. Jones and it by-passed the heads of departments and subdepartments—obviously an unhappy situation.

The final and seemingly ideal communications plan leaves the responsibility entirely in the hands of the conference president, Mrs. Travaille. She is authorized by the conference delegates to follow through on any of the problems which cannot be ironed out within the group itself.

Armed with the minutes of the last meeting, she calls on all the subdepartmental and departmental supervisors concerned. When they can act on or explain away complaints, they do. Those items in the conference meeting minutes which they cannot or do not wish to handle are taken, with their full knowledge and understanding, to the next meeting of the administrative council.

This group, which meets monthly, two weeks after the conference meetings, is composed of Mr. Booth, Mrs. Jones, the director of nurses, the chief dietitian, the superintendent of maintenance, the executive housekeeper, the assistant administrator, the chief admitting nurse, the purchasing agent and credit manager, the personnel manager, and the administrative resident.

Mrs. Travaille, still clutching her minutes, appears in person before the council to plead the causes of her delegates. Where her pleas are successful, she carries the good news back to the next meeting of the conference; where they are not, she returns armed at least with explanations bearing the backing of an open discussion within the council. No single important decision is ever made secretly or without explanation.

So far the internal organization of the conference has been notable for its extreme informality. The two officers have served from the start and, while no delegate has suggested a change, both feel it is time for another election, and perhaps for a constitution, a set of by-laws or something of the sort. It has also been suggested that some official method of selecting dele-

gates be established. However, no one seems to take this last idea seriously and there is a general feeling that the air of informality should be retained. As it is now, the employees in a given group simply unload their ideas and troubles onto their likeliest and most willing fellow and send him off to the meeting. If he's not available, someone else goes in his stead. Actually, at many meetings a subdepartment may be represented by as many as two or three persons.

To date the problems tackled by the conference can mostly be listed under the heading of gripes. However, conference delegates, having now cleared away a large backlog of relatively minor complaints, are beginning to assume a more mature attitude and are setting their sights on wider and more basic plans.

THEY'RE PLANNING A PARTY

The conference, for instance, is currently discussing plans for an annual employee gathering of some sort—something the administration has been thinking about for years. The idea, pushed by nearly all the delegates, seems to be starting to jell in the form of a picnic. While this may seem a minor item, it is an indication that the conference perspective is shifting from personal complaints involving one or a few to a general outlook involving the entire staff.

Still another problem which Mr. Booth has never been able to solve and which he has willingly tossed to the conference concerns some means of rewarding employees who do not use up their sick leave without angering those who have been legitimately ill. The conference is working on the problem, and Mr. Booth is certain the members will come up with a solution.

While officially the conference has no part in the orientation of new employees, actually it serves as an effective means of welcoming a new member into the St. Francis family. The new employee is informed immediately of the conference and its functions and is invited and urged to participate in the meetings.

As this is written, it is six months since the conference was born. It is just now beginning to mature. Many of the participants feel it is likely soon to become one of the hospital's most vital forces for good. No one has yet spoken out against the plan. And meanwhile, Mr. Booth and Mrs. Jones wonder how they ever lived without it.

Autoclaving Tape

**makes life easier for the central supply staff
by speeding preparations for sterilizing packs**

MINNA E. MOEHRING

Operating Room Supervisor
Ancker Hospital, St. Paul

A NOTABLE improvement in the autoclaving procedure employed at Ancker Hospital, St. Paul, during the past few months has ended the need for tying, tucking or pinning bundles prior to autoclaving in the operating room and central supply departments.

The improvement—a new method

for sealing and identifying autoclave bundles easier, faster and more efficiently with pressure-sensitive tape—calls for use of short strips of a high temperature pressure-sensitive tape for the bundle sealing job, a tape able to withstand autoclaving without drying out, curling, stretching or coming loose.

Under test, the tape was found to retain its active "hold" during prolonged exposure to high steam temperatures (up to 250° F.), yet was removed easily from linens, jars, tubes and canisters without leaving stains or gummy residue.

We also found that pencil, ink or crayon identification markings on the

Left: Contents of "lower field pack" stacked on wrapper as back corner of wrapper is brought up over the contents. Center: After the sides of the wrapper have been tucked in, the remaining portion of the wrapper's sides

are folded over the top to make the pack snug. Right: After an extra fold has been made and the remaining end of the wrapper has been brought around to complete the wrapping, the pack is ready to be sealed.





Left: The end of the wrapper is made secure with a 3 inch strip of tape. Center: Pack contents are identified

by a penciled notation made on the backing of the tape.
Right: Completed packs are stacked in hand truck.

tape did not blot or fade into its paper backing, or into the linen bundle-wraps. Previously, we were identifying our tied or pinned bundles by writing on the linen, thus necessitating extra laundering and bleaching to remove the markings before the linens could be reused.

Since adopting the new taping method we have found it to be aseptically positive, and as good as or better than existing sealing methods. Comparison revealed:

1. String tying is comparatively slow and tiring owing to the physical

effort required to lift and turn the heavy bundles. Also, because pressure within the autoclave during sterilization tends to compress the linen bundles, the outer wrap often came loose and subsequent handling resulted in opened bundles that had to be reautoclaved at added expense and loss of time.

2. Pinning, on the other hand, was found to be less aseptically positive than tying, as the pins tended to work out of the bundle in handling and storage. Because such loose pins are considered contaminated, they could not

be reinserted without the entire bundle's being reautoclaved. Also, pins that are not removed from the wrapping before laundering often tore the linen during washing, or pricked or scratched the laundry's personnel during handling.

3. The "tuck-in" or interlocking fold method required greater physical strength and adeptness than other methods and the packages had a greater tendency to come undone during handling.

With the new sealing method, all that is needed are short strips of the

Left: A series of small packs being made up, with the tape used to effect the seal. Right: This group of photo-

graphs shows the three conventional methods of sealing: top, left—tying; top right—pinning; bottom—tucking.



high temperature tape to effect the seal after the pack has been formed. On most packs a single 1 inch wide by 3 inch long strip is adequate, while two or more strips can be used to seal larger bundles.

The tape's pressure-sensitive adhesive sticks at a touch to the linens, as well as to metal, paper, glass, plastic, wood and other clean, dry surfaces, yet removes easily and cleanly without discoloring linens or leaving adhesive residue. Should a strip of the tape be left on the linen during laundering, it does not gum up or clog the laundry equipment.

SAVES TIME AND COST

During use we have found many other advantages for the taping method over the previous methods. Among these were:

1. *Reduction of time and labor costs:* Packs can be wrapped and sealed in a fraction of the time required by other methods. As a result, we have been able to record an average pack-preparation saving of from 2 to 5 cents per surgical procedure.

2. *Neat, secure packs:* Bundles sealed with the tape are more compact, require less storage space, and are easier to handle without danger of accidental opening; thus, fewer packs need reautoclaving.

3. *Easy labeling:* The tape serves as both a seal and a label, and may be written on with any pencil, ink or ball-point pen for clear, positive identification of the individual packs.

4. *Convenient:* Both the sealing and subsequent opening of the bundles are fast and easy.

5. *Safe:* The tape doesn't cut into the bundles, tear linens or injure personnel.

6. *Inexpensive:* One 60 yard roll of the high temperature tape will seal approximately 720 bundles, at an average sealing cost of six bundles for 1 cent.

In addition, we found the tape can be used for labeling all types of trays, pans, jars, canisters and tubes. These labels resist moisture after application, withstand repeated autoclaving, and remove easily without leaving adhesive residue on the surface of the labeled object.

It can also be used to secure loose metal tray covers and the coverings for small tubes, such as those containing hypodermic syringes, to assure against contamination of the contents.

Strips of surgical plaster (top) and pressure tape (bottom) were applied at the same time to this canister for thumb sponges prior to being autoclaved. The canister was first cleaned and dried thoroughly.



During a 24 day period of normal use the canister was re-autoclaved six times. At this point the surgical plaster showed signs of breaking down and coming loose. Pressure tape was not adversely affected.



"Nursing force report" answers the question:

How Much Nursing Care Are We Giving?

A. C. O'CONNOR

Assistant Director
Mount Sinai Hospital
Cleveland

HARRY C. BACH

Administrator
Mary Washington Hospital
Fredericksburg, Va.

A PATIENT entering a hospital expects to receive adequate care and the hospital enters into an implied contract to give such care. Nursing department personnel, composed of registered nurses, students and non-professional or auxiliary nursing personnel, ordinarily give the direct care to the patient. Therefore, it becomes the responsibility of the hospital to furnish a sufficient number of nursing personnel to render adequate care and to ensure that this care is adequate not only in number but also in quality.

Head nurses responsible and concerned with the staffing of their units should have sufficient personnel to give adequate care to the patients. At Middletown Hospital, Middletown, Ohio, we had available a fairly satisfactory report on the quality of our nursing care from comments made by patients in our patient opinion questionnaire. We had used this questionnaire for nearly three years at the time we gave serious thought to the development of a daily report of general nursing hours per patient.

The nursing service office had no accurate way to check the amount of care rendered as it relates to census per nursing station. The administrator was not in a position to determine if the budget dollar was being spent wisely, nor was he able to satisfy himself in a short period that ample care was being given to the patients. Although daily and weekly time schedules were available, it was difficult for the personnel office properly to evaluate requisitions for additional personnel. The pressure for more personnel from

aggressive head nurses could not be satisfactorily answered.

The notations on the patient opinion questionnaires informed us that the nursing care was good but that we did not have enough nursing personnel. Also, applicants coming to the personnel office stated that when their relatives were in the hospital we were drastically short on nursing personnel, especially nurse's aides; however, they admitted that their relatives had received good care. We came to the conclusion that patients were being told that there was a shortage of personnel and the informant no doubt was honest in his thought, even though the patient was satisfied with the nursing care he had received.

With the complete cooperation of the director of nursing service and her assistants, we began our search for an answer to our problem. The latest and seemingly best available information was set forth in the "Hospital Nursing Service Manual," published in 1950 based on a joint study by the committee of the American Hospital Association and the National League of Nursing Education.

A seemingly logical approach to the problem was to borrow from industry its "force report." As used in industry, this report provides the number of man-hours worked and the number of units produced, thereby giving the productivity of the individual. It was immediately recognized that such application to patient care would not be acceptable as we were approaching the problem in a reverse pattern. We wished to be sure that we were giving the acceptable minimum number of hours' care per patient per day. We decided that the minimum hours rec-

ommended in the "Hospital Service Manual" would be our goal. To test it as applied to our hospital, we felt that our patient opinion questionnaires would reveal if the patients were satisfied with the service, since they constitute the judge and jury in matters of patient care. The report form that was finally accepted was tailored to fit our particular hospital as to nursing units and type of personnel (Fig. 1).

The different nursing units were listed by initials across the top of the form. Directly down the side of the form we listed the three categories of personnel we were using in our nursing department, consisting of professional, student nurses, and nonprofessional. Under each category we provided a space for total hours with a space at the bottom for grand total hours. Another breakdown was made in each section indicating full time, part time, students by school year, orderlies, and volunteer Red Cross nurse's aides. Under the nursing station designation, we set up three columns indicating the different shifts. This was considered highly essential to be sure that the individual head nurses were not overloading a certain shift when they made the assignment schedules. Personnel working in central supply and operating room were not included in the report, as we were working only with the bedside care phase of the nursing problem. Floor secretaries, however, were included under nonprofessional hours as it was felt that the work they did would have to be done by a nurse if they were not present.

Private duty nursing hours were not included in the total general nursing

This analysis was made when Mr. Bach and Mr. O'Connor were at Middletown Hospital, Middletown, Ohio.

hours. Instead, the patient census was reduced by one-third for each eight-hour period a private duty nurse was on duty. This was entered in the report in parenthesis beside the reduced patient census figure. It was decided to use this method of computing hours of care per patient so as not to alter the total general nursing hours rendered by both paid and volunteer personnel.

Each day the nursing office secretary enters the number of hours for each unit in the proper category, obtaining this information from the daily time schedule of the previous day.

This corrected schedule reflects the exact number of persons on duty and not the number assigned to the unit, thereby eliminating those absent for illness or other unscheduled time off. The census was obtained from the census report for the previous day. We realized that the variation in patient census, coupled with unscheduled time off, would bring some variation

in the hours of care per patient; therefore, we elected to use a period of one week as our measure. The daily reports are placed in a looseleaf binder and after each week another form (Fig. 2) is inserted on which is listed the total census, as well as the total hours of care rendered to each nursing unit. In addition, the per cent of professional, student, and nonprofessional hours are computed on the weekly report.

The report when completed each day is studied by the director of nursing service and her assistants; the administrator, assistant administrator, and the personnel office. Any one of these persons can readily determine at a quick glance the average amount of care rendered per patient per day. If a unit is below the acceptable average, a glance will indicate if there has been a marked increase in census, such as frequently occurs in obstetrics or pediatrics. There may have been an apparent surplus of personnel owing to

a sharp drop in census. There are, of course, fluctuations in the number of available registered nurses and students, and as the numbers vary, it is sometimes necessary to use nonprofessional and part-time help to maintain a satisfactory operating level.

In addition to the "Report of General Nursing Hours per Patient per Day" weekly computation, a line graph chart was maintained on which was shown the number of hours for each nursing unit. These various reports provided us with an excellent idea of the utilization of available nursing department personnel, and, of course, it was understood that the information they contained was history. However, using the past, and combining it with the available information as to possible resignations and additions to the staff, we felt we were fairly well abreast of the situation at all times.

After using these reports since their inauguration July 1, 1951, we believe we have a readily workable report,

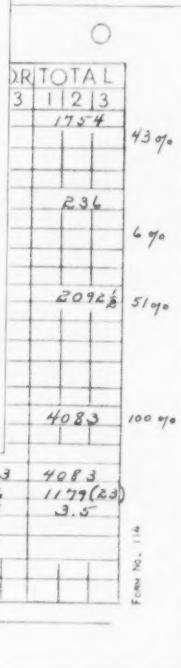
NURSING HRS PER PTN DAY	S.W.	P.C.	G.F.	C.W.	NURSRY	OB-DR	TOTAL														
PROFESSIONAL	1 1 2 1 3	1 1 2 1 3	1 1 2 1 3	1 1 2 1 3	1 1 2 1 3	1 1 2 1 3	1 1 2 1 3														
F.T.	24	8	8	20	4	8	27	5	8	16	8	8	24	16	16	103	53	56			
P.T.	6			8		6		4					6				18	12			
TOTAL PROF	30	8	8	20	12	8	27	9	8	16	8	8	30	16	16	141	65	56			
STUDENTS																					
1st																					
2nd																					
3rd																					
TOTAL STNTS	7		5	7	7								5		5		15	14	7		
NON PROF.																					
F.T.	31	13	8	39	17	8	27	5	2	28	12	25	11	8	55	17	8	205	75	32	
P.T.	7	2																7	2		
ORD.	8																	8	8		
VOL.																					
TOTAL NP	31	13	8	54	19	16	27	5	2	28	10	25	11	8	55	17	8	220	77	40	
TOTALS	61	28	16	79	38	31	45	17	8	55	21	8	46	19	16	90	33	24	37	65	103
TOTAL HOURS	105		148		70	2	84			81		147			635	2					
CENSUS	30	(3)	42	20	3	(1/3)	17			.77		34			180	2	(3)				
HRS. PER PTN.	3.5		3.5	3.4			4.9			2.2		4.3			3.5						
PD. PTNS.	4	3	2				1											1	2	3	4
P.D. HRS.	32	24	16				8											2	3	4	5
CALL ORD.	8	8																4	5	6	7
24 HR. PERIOD ENDING 7:00 A.M. Tuesday																					

Fig. 2: The weekly report lists the total census, total hours of care rendered each unit, and per cent of hours by categories of personnel.

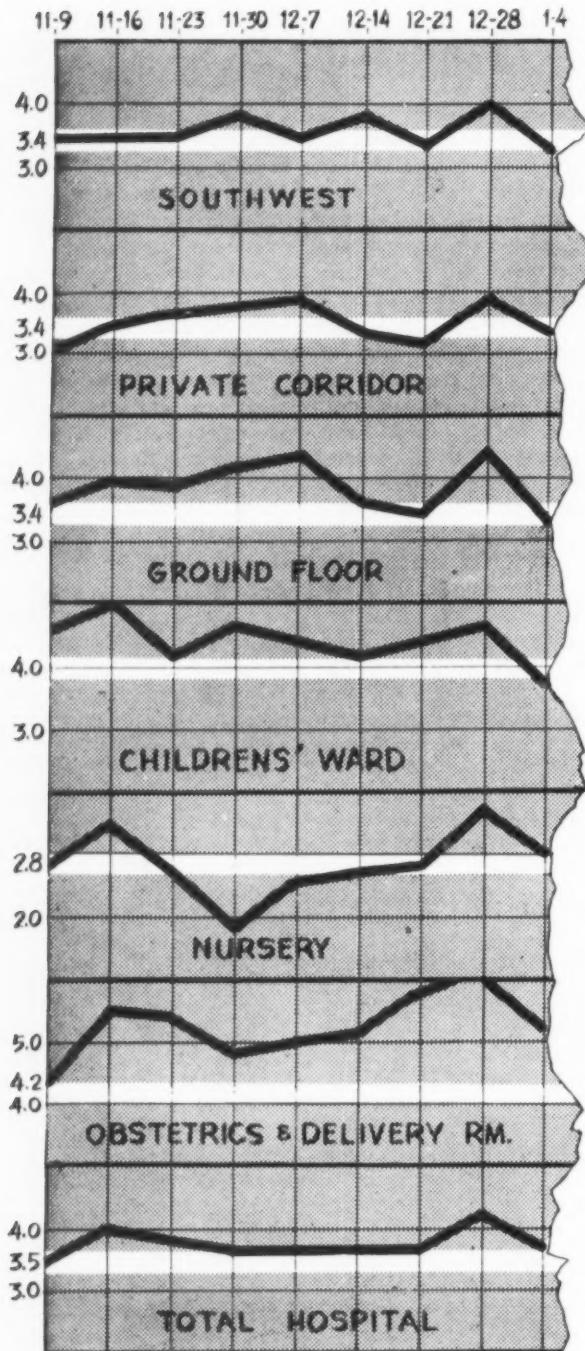
TOTAL HOURS	74.3	96.9	488 1/2	453 1/2	486	94.3	408.3
CENSUS	204 1/2 (21 1/2)	286	146 1/2 (17 1/2)	106	81.4	216	1177 (23 3/4)
HRS. PER PTN.	3.6	3.4	3.3	4.3	2.2	4.4	3.5
RD. PTNS.							
P.D. HRS.							
CALL ORD.							

WEEK ENDING 7:00 A.M.

Fig. 1: The report form lists the various nursing units by initials across the top and the three categories of personnel down left-hand side.



GENERAL NURSING HOURS
November 9 Through January 1.



Line graph showing number of hours for each nursing unit.

which does not involve too much clerical time, and has provided us with more answers than we originally sought. The feeling that the head nurses were overloading certain shifts and leaving others uncovered was soon dispelled. To our amazement and satisfaction we found that an excellent job of assignment was being carried out. The reports of shortages of personnel that had been heard before seemed to disappear except when we were actually short as indicated on the reports.

The nursing service office is pleased with the report as it provides a quick check on how the head nurses are handling their personnel. Figures and charts seem to mean much more to people than do unsubstantiated explanation. It has definitely helped the nursing service office in assuring head nurses that they were well off personnel-wise.

The report is particularly helpful to the administrator and the assistant administrator, as it gives prompt, accurate information. Our experience to date indicates that the minimum hours recommended in the "Nursing Service Manual" seem to satisfy the patient whom we consider the final authority. We were dubious about the substitution of nonprofessional hours for professional hours but believed that it could be safely done and would be readily accepted by the patients. The burden of making it a success, of course, fell directly on the head nurse, who has to use her available personnel to the greatest advantage.

The personnel office is materially benefited by these reports and is aware of the need almost as soon as the nursing office. The doubt that existed previously regarding the requisition for personnel has been eliminated. The small student body that was available for floor assignment varies from time to time according to the number of students away on affiliations. This knowledge, coupled with the available reports, enabled the personnel office in cooperating with the nursing service office to take action covering these openings.

This procedure in no way provides the additional nurses so badly needed throughout the country, whether they are degree, diploma, practical nurses, or trained aides. It does provide the administrator and his assistant some assurance that the implied contract between the hospital and patient is being fulfilled by the hospital in the best available manner.

This Hospital Knows What It's Worth

**A detailed record and valuation of all assets
is worth the time and money spent making it**

WE AT Pontiac General Hospital have known for some years that not all of the hospital owned fixed assets were recorded on the books. As a result, the proper amount of depreciation, even on a cost basis, was not being provided. In recent years, owing to the substantial additional monies required to replace properties at currently higher costs, this has become even more significant in the hospital's operations. Insurance coverage was based on estimated current values of the buildings and equipment, and in the event of a fire the hospital would be unable to establish that adequate co-insurance was being maintained or to identify the assets destroyed.

A review of the records showed that on Jan. 1, 1947, all of the assets had been transferred in lump sums from the city of Pontiac accounts to a separate set of accounts maintained by the hospital. All detailed records available at that date were found to be inadequate and incomplete. Additions since that date had been recorded at cost, and invoices and other supporting data had been preserved.

In 1952 it was decided that the task of identifying and preparing a detailed record of all hospital assets could no longer be deferred. It was also decided that such a record should include original cost for accounting purposes, reproductive value for cash budget requirements purposes, and second value for insurance purposes. The proposed program was broken down into the following steps:

1. Hospital employees would attach metal numbered tags to all hospital equipment and at the same time prepare a numerical listing showing tag number, description and location.

2. An appraisal company would be engaged to furnish the hospital with a detailed appraisal including original cost, reproductive cost, sound value

LAURETTA PAUL

Director
Pontiac General Hospital
Pontiac, Mich.

and insurable value. The detailed appraisal record provided would include the tag numbers as well as technical descriptions and location.

3. The original cost value, as determined by the appraisal company, together with a reserve representing the depreciation which should have been taken to date, would be entered in the hospital books and used as a basis for providing future depreciation.

4. All new equipment purchased would be numbered and the numerical listing would be maintained by the hospital with changes recorded thereon. Additions and disposals would be reported currently to the appraisal company which would maintain detailed records. Based upon current year's changes and percentage trends applied to previous year's additions, the appraisal company would reevaluate annually the current reproductive, sound and insurable values. With these data detailed, property records could be maintained. The following excerpts from instructions issued to hospital personnel show briefly the procedures followed:

Identification Tags:

1. A single serially numbered metal tag will be used.

2. The initial numbering of properties on hand will be done starting with No. 1 in the southwest corner of the basement and running in numerical order around each floor in ascending order for the main hospital buildings and progressing thereafter to the power house and separate residences.

3. Tags will be placed on each piece of equipment in the locations shown by the master tagging list (left rear leg of chairs).

4. Numbers will not be assigned to buildings, heating plant system, electrical system, or other minor systems, as these will be given separate identifying codes.

5. In general, all depreciable equipment listed in Section I of the "Handbook on Accounting, Statistics and Business Office Procedure for Hospitals" will be tagged.

6. All identification tags will be placed prior to the beginning of the appraisal.

General Ledger Controls:

1. The following general ledger accounts will be maintained and depreciation computed over the estimated lives noted:

	Estimated Life
Land	
Buildings: Brick, steel and	
concrete	50 years
Frame	25 years
Furniture and equipment	10 years
Autos and trucks	5 years
Minor equipment	Nondepreciable

2. The general ledger will be adjusted to reflect original cost and accumulated depreciation that should have been taken thereon, as determined by the appraisal company.

3. Depreciation will be computed on lapse depreciation schedules only and will not be maintained for each item of equipment. One-half year's depreciation will be provided in the year of acquisition and in the year of disposal.

4. Minor equipment, such as wastebaskets, desk trays, bedpans, dressing jars, syringes, catheters, basins, hemostats, glassware, silverware, pots and pans, sheets, blankets, mattresses, ladders, mops, buckets and so on, in use

in the hospital will be inventoried on a separate list by a special crew and set up on an imprest basis. Replacements will be charged to expense and the equipment will be inventoried periodically to determine the value on hand and in use.

New Equipment Purchases:

1. As new equipment is ordered the purchasing department will indicate on the receiving copy of the purchase order that the item is to be tagged.
2. The receiving clerk will attach the next numerical tag to the equip-

BRIEF ANNUAL REPORT

THIS is the story of a new hospital. It is a brief story of Memorial Hospital's first fiscal year of operation. That year started April 1, 1952, and ended March 31, 1953. Ninety-two per cent of the beds were occupied every day of this first year, many days (and nights) every bed was filled.

The building itself may be a beautiful monument in masonry, equipped and shining with sterility and stainless steel. It may also be a social institu-

tion, expending substantial sums of the community's money in the community service. But it can never function to its optimum effectiveness until its physical, human and spiritual resources are integrated, to focus, with efficiency and intelligent understanding, on the single individual patient. This is the prime purpose of a hospital.—*Annual Report of the MEMORIAL HOSPITAL ASSOCIATION OF CHARLES-W. VA.*

ment as it is received and show "Equipment Tag No. —" on the receiving copy of the purchase order.

3. The receiving clerk will maintain a dated numerical list of all tag numbers assigned and a description of the item, including serial numbers and manufacturer's name.
4. The accountant will maintain an

4. The accountant will maintain an identical list and upon receipt of the processed voucher from the accounts payable clerk, the accountant will follow up and correct any exceptions, such as numbers assigned to other than capital items and capital items missed in assigning numbers.

New Equipment Constructed by Hospital:

1. The maintenance department will forward copies of all completed work requisitions to the accountant, who will review the work performed to determine if any items carried in the property accounts have been dismantled or any items which should be capitalized have been constructed or installed.

2. The accountant will follow up the relieving of the property records for capital items dismantled and the assigning of tag numbers and recording of costs for items to be capitalized.

Properties Disposed of:

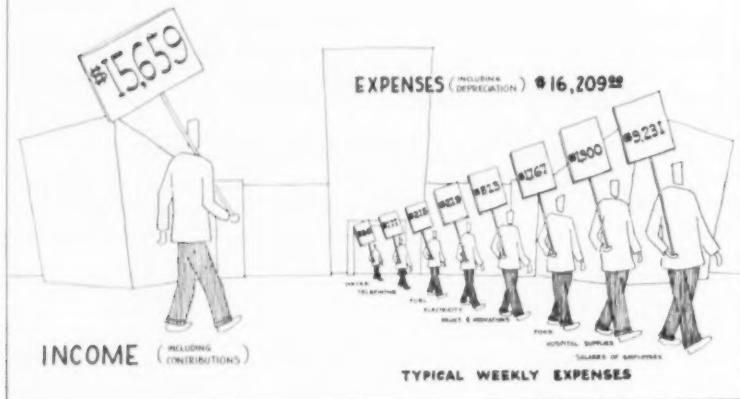
1. The identification tag will be removed and forwarded to the account-ant with the written disposal authori-zation for all property items sold, traded in, scrapped or otherwise dis-posed of.

2. The accountant will follow up to ascertain that the proceeds or credit is received and the transaction properly recorded in the accounts and numerical property listing.

The appraisal has now been completed and the adjusting entries were made in the hospital records as of Dec. 31, 1952. The results were much as we anticipated and showed that a substantial portion of the properties, particularly buildings, had never been recorded in the accounts. The reproductive and sound values have served to emphasize the amount of insurance necessary for adequate protection, as well as the funds which will be needed for future expansion and replacements.

The program presented many months of hard work by hospital personnel, as well as a considerable cash outlay, but we all feel the results justified the efforts and expenditures.

MEMORIAL'S FINANCES - EACH WEEK OF THE YEAR



AN AVERAGE WEEK AT MEMORIAL HOSPITAL



Modernization helps to make a

Medical Center in Miniature

WALTER R. HOEFLIN Jr.

Administrator, Methodist Hospital of Southern California, Los Angeles

TO DAY, a hospital must not only maintain adequate facilities for the sick but must also be wholeheartedly interested in the prevention of sickness and the active promotion of health. Only by having a clinic or other teaching facilities, or a variety of diagnostic and therapeutic resources, and above all, a program of action, can a hospital gain acceptance by citizens who will become active "partners" in spreading the word of the worth-while program of the hospital.

Methodist Hospital of Southern California, Los Angeles, felt this responsibility to the residents in its immediate area. Thirty-eight years had seen the neighborhood change from high-income, single-residence dwellings, to low-income, multiple housing for people of all races, and manufacturing enterprise. The need for an outpatient clinic was great, but funds to build such a structure were nonexistent.

Informed of the details of the proposed clinic and the principle of a small-scale medical center to serve a limited area, members of the medical staff responded with enthusiasm and contributed almost \$75,000, a sum sufficient to both build and equip the clinic. A special committee held numerous conferences with a hospital architect, working with him on size and placement of rooms to provide maximum utility from a doctor's standpoint.

The clinic building proved to be a gem of its kind. Because so many clinics have been housed in buildings condemned for most purposes, this new clinic building and its shining new equipment spark enthusiasm in patients, personnel and doctors alike. Measuring approximately 36 by 102 feet, it has been economically maintained by a minimum employed staff

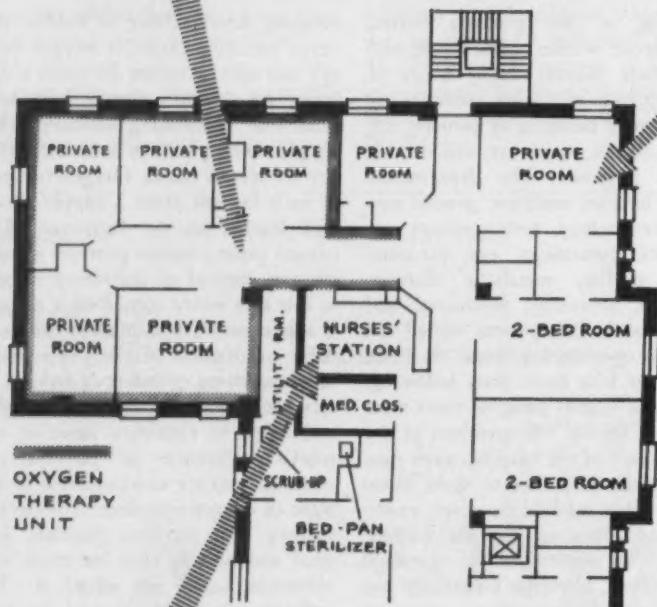
consisting of two graduate nurses, social service worker, nurse's aide, and a part-time janitor. Many hours of volunteer help each week assist greatly in the proper handling of patients. Of the 19 rooms, seven are utilized for medical purposes. The departments include internal medicine, general surgery, dermatology, genito-urinary, orthopedics, gynecology, eye, ear-nose-throat, cardiac, metabolic diseases, pediatrics, neurology, psychiatry, and tumor board. One patient visited the clinic on opening day, June 15, 1949, but in the four short years following, more than 22,800 patients' visits were recorded. Of the 300 members of the medical staff of the hospital, more than half donate their time to some phase of the clinic medical program, examining and treating patients without charge. To implement the operation of the clinic, a women's auxiliary was organized and a program of continuous fund raising was introduced.

With the clinic successfully launched, the Methodist Hospital embarked on the second phase of its progressive program of growth and development. Work is constantly going on to modernize the five-story main building and revamp all departments on a "work-flow" basis. The changes have already resulted in a substantial saving of man-hours by eliminating waste motion. New departments are being created to meet special needs. Of special note is the oxygen therapy unit. Through the conversion of a space in one wing of the hospital which for 25 years had been used exclusively for sleeping quarters for residents and interns, a unit of five private rooms was made available for critically ill cardiac patients. The unit features special facilities and separate nursing personnel as standard procedure. The usually

accepted standard care of cardiac patients requiring extensive oxygen therapy and special nurses 24 hours a day bring the patient's already high hospital bills to alarming amounts. This oxygen therapy unit obviates the necessity for special nurses. Oxygen is piped to each bedside from a supply manifold located in the basement. The oxygen piping system provides a more efficient method of delivering oxygen to this area where considerable oxygen is administered. It eliminates the usual delay and hazards of fire and accident in transporting cylinders of oxygen in elevators, corridors and patient units, and helps to eliminate some of the morbid inferences of patients and relatives who are unaccustomed to the sight of oxygen cylinders. The oxygen therapy unit provides excellent hospital and nursing care for those who otherwise could not afford it. The ordinary cost for the care of the critically ill cardiac patient is cut in half.

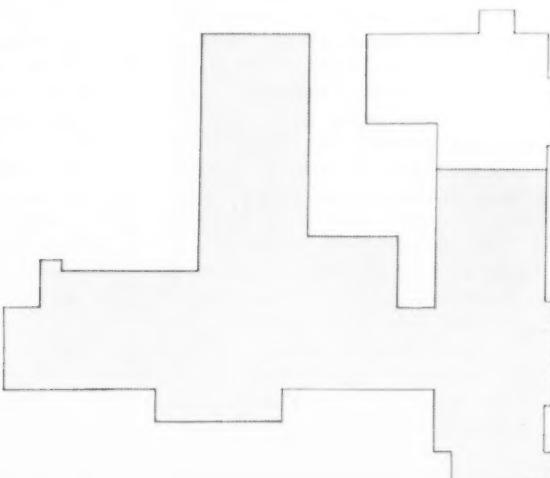
Decentralization of nursing stations is another feature initiated at Methodist Hospital. By establishing a new nurses' station in the middle of each wing, we have cut the nurses' "running time" and "mileage" down to a minimum. This change also obviously reduces the usual commotion at the nursing stations as but one-half of the usual number of nurses and doctors are assigned there.

Major changes in the maternity department have been completed to comply with modern technics. Two new nurseries, including a premature facility and a suspect area, as well as a new delivery suite, have been commended by various health agencies. Oxygen is also piped to these areas. A rooming-in unit is another new department. (**For plans and photographs, see pages 80 and 81.**)

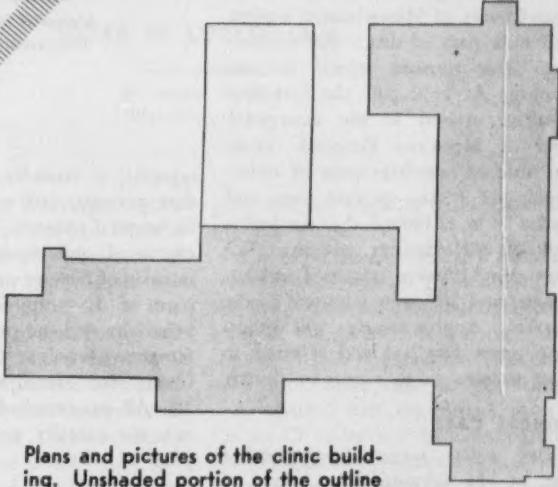
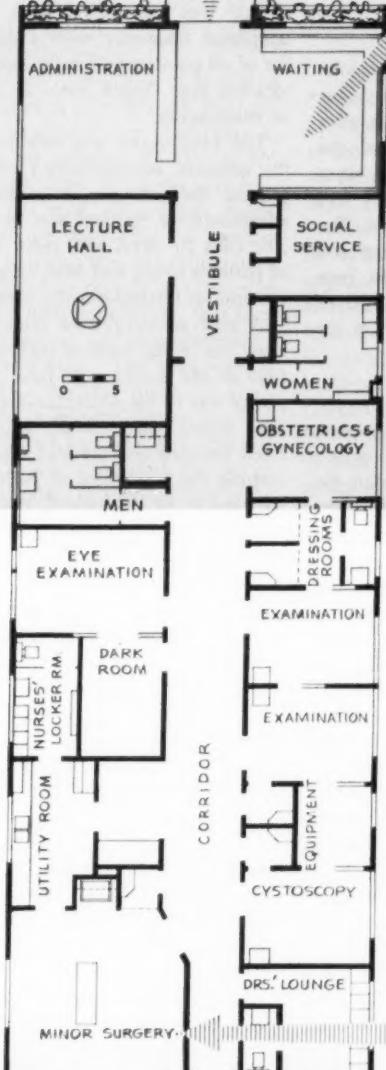


Modernization

Plans and pictures of oxygen therapy unit. Unshaded portion of plan below shows relation of this area to remainder of the floor. Photographs illustrate: top, left, corridor of oxygen therapy unit; top, right, a private room with oxygen outlets; bottom, left, closeup of the nurses' station with the control panel for the piping system.



THE MODERN HOSPITAL



Plans and pictures of the clinic building. Unshaded portion of the outline plan shows relation of the clinic to the hospital proper. Top, left: Entrance to the clinic. Top, right: the lobby. Below: one of the minor surgery rooms.

METHODIST HOSPITAL OF SOUTHERN CALIFORNIA



When the Tornado Turned Up in Worcester

1. Memorial Hospital Learned From the Experience

ON JUNE 9, 1953, at 4:40 p.m. a tornado passed through Worcester County of Massachusetts leaving a 50 mile path of death and destruction. The tornado struck without warning. At 5:30 p.m. the first four casualties arrived in the emergency room of Memorial Hospital. From that time on casualties came in ambulances, fire trucks, private cars, and trucks. It is estimated that we had a total of 300 disaster patients. We know that 119 were examined and discharged and 109 were admitted to the hospital. Approximately 100 others were given first aid and referred to other stations or to a near-by church.

MEDICAL CARE

Five senior surgeons were called first by the administration. One of these doctors was assigned to the entrance of the outpatient building. He sorted and directed patients to examining rooms, first-aid stations, and finally into the corridors.

On arrival, members of the staff took stations in the examining rooms and other parts of the hospital. The patients were examined, treated and then referred to other departments, such as x-ray, plaster room, the surgeries, or admitted to the hospital. Children were sent to the pediatric ward where they were seen by the pediatrician. Two temporary wards were set up in the staff room and library. By 1 a.m. June 10, the surgeries had been cleared and all patients had been admitted. The outpatient department was cleaned and ready for regular use at 8 a.m.

At 8:30 a.m. on June 10, the medical staff met. The objectives of this meeting were to organize medical teams to evaluate and devise methods of continued treatment of the hospitalized casualties, to review the bed

WINTHROP B. OSGOOD, M.D.

Administrator
Memorial Hospital
Worcester, Mass.

capacity, to consider ways to consolidate patients, and to discharge regular hospital patients. Three wards were evacuated and made ready for the transfer of disaster patients from other parts of the hospital where they had been admitted the previous night. The temporary wards in the staff room and library were closed at 6 p.m. on June 10. All patients had been transferred into the casualty wards by 2 a.m. on June 11.

DEPARTMENTAL OPERATION

During the early evening of June 9, all hospital departments were opened and in operation. These included the storeroom, laundry, blood bank, pharmacy, central supply, dining room, and coffee shop.

The administrative setup was much like that of the usual disaster plan. The administrative offices were open continuously day and night, from 5:30 p.m. June 9 until 6 p.m. on the 11th. The three offices and the trustee room provided ideal facilities for the various centers. The telephones were intercommunicating with four direct ninth level lines to the outside. In this area we set up an information or message center, a press room, a staff administrative center, and a transfer center.

The personnel director, with the assistance of a volunteer trustee, organized the information center. The telephone operators and others were instructed to refer all calls for information, inquiry, requests for supplies to

this office. Volunteers acted as messengers. A list of patients treated, discharged and admitted was kept on cards. This office was opened at 7:30 p.m. June 9 and was fully manned until 10 a.m. on the 11th when this service was transferred back to the telephone operators with a complete list of all patients and their conditions, location and classification as casualty or noncasualty.

The press room was established in the assistant administrator's office adjoining the information center. The administrative resident was in charge. The calls by press and radio for lists of patients living and dead were almost continuous throughout the night.

A staff administrative center developed out of the medical staff meetings held on the morning of June 10. This center was in the administrator's office. The center received all information from the staff and the staff teams concerning the conditions of patients, the patients to be discharged, and the requests for transfer. We were advised of the doctors to be assigned for night coverage on the 10th.

This center soon became a transfer center. The personnel of this center consisted of the administrator, assistant administrator, administrative resident, an admitting officer, a volunteer and a nurse. All admissions, discharges and transfers were cleared in this office. The admitting officer acted as an adviser and liaison with the admitting office. A representative of volunteers assumed coverage to take incoming messages and to make arrangements with the motor corps for transportation. The nursing representative effected the transfers.

Social service accepted an assignment to the information center first. On the 11th this department began a social service survey of all hospitalized

disaster patients. The department appended a report to each record. The information was available to doctors at all times.

The volunteers rendered an important and necessary service in the care of disaster patients. We really had no idea of the large number of volunteers reporting. We do know that 72 nurse aides came on duty the night of the disaster; five volunteer phlebotomists went to the blood bank; 14 surgical groups immediately began work in homes and churches. Other volunteers reporting to the hospital organized three surgical supply groups in the volunteer office. Many others were assigned to various departments in the hospital including the laundry.

EVALUATION WITH COMMENTS

It is not possible to report the activities of all the departments or of the people who helped us. The response was really unbelievable!

As in every experience of this kind there are lessons to be learned. We have carefully evaluated our operations in this time of emergency. We would like to share some of the recommendations of our staff, department heads, and others for improving our service. You will note that several of them have been included in reports of other disasters. We believe, however, that they deserve repeating and reemphasizing.

Communications. The telephone is outmoded as the best means of communication in disaster. In our particular instance, we had only one operator on duty. It was impossible for her to call the members of the staff and other key personnel with dispatch. This was done by the chief dietitian on a direct ninth level telephone. It would seem advisable, therefore, to have direct communication by radio with the police department, fire department and civilian defense. This would permit the sounding of one-coded call by the audio alarm system of civilian defense for all staff members and personnel to report to the hospital. It would also provide a means of requesting police or fire assistance if telephones were out of order. Short-wave radio intercommunication in the hospital is deserving of consideration. We were fortunate in having a dial intercommunication system of telephones in the hospital and a large number of direct ninth level lines to the outside.

Traffic and Police Control. The corridors of the outpatient department

soon became congested because of the large number of casualty patients and visitors. Guards should be posted at all entrances to keep out the sightseers and to direct visitors and inquirers to the information center. Provisions should be made for one-way traffic for ambulances. We plan to install an additional exit for this purpose.

Identification. Many of our person-

nel and volunteers had difficulty in getting to the hospital on the night of the disaster and later. All members of the hospital disaster organization should have identification passes. It also affords a means of keeping out unauthorized persons.

Key Personnel. We strongly recommend that members of the administra-

(Continued on Page 140)

2. There Were Only Minor Flaws in St. Vincent's Disaster Plan

SISTER M. LORETO, R.N.

Administrator
St. Vincent Hospital
Worcester, Mass.

THE tornado in Worcester created many problems, not the least of which was a sudden flooding of all the hospitals in the city with casualties.

How we met this emergency will be outlined in detail here. How well organized we were has not been fully assessed but, while the experience is fresh in our minds, it is well to record the incident in some detail.

About the time of the onset of the Korean affair the nation in general and Worcester in particular again began to plan for trouble. Worcester, being a highly industrialized community of 205,000, was felt to be a possible primary and surely a secondary target in the event of an all-out atomic war. City, county and state officials set up civil defense organizations to meet any emergency.

At the same time the president of the medical staff of St. Vincent Hospital appointed a hospital civil defense committee to represent the hospital and cooperate with government workers. It also functioned to organize the medical, nursing and administrative staffs of the hospital. Over a period of several months the committee worked out a plan for the use of the hospital facilities in a disaster. Recommendations to the administration were made for obtaining adequate supplies. The functions of the various departments were outlined. The entire plan was presented to the medical and administrative staffs and approved. This

plan was our working basis when the big blow came.

It is to be remembered that St. Vincent Hospital was the most distant of the five Worcester hospitals from the scene of the disaster. It was therefore the last to receive casualties. This gave us a little more time to get ready.

At about 5 p.m. the tornado struck and in 15 minutes it had crossed the city. As soon as the general population became vaguely aware of the magnitude of the disaster, medical, administrative and nursing personnel reported to the hospital for duty without being bidden. At 6:35 p.m. the first casualty arrived and by 11 p.m. admissions were slowing to a walk.

The nurses' dining room, 40 feet from the ambulance entrance, was cleared for use as a sorting station. It functioned (1) to dispatch seriously injured casualties to the emergency surgery, (2) to treat minor injuries that could promptly be discharged, and (3) to admit casualties directly into wards. At this station a large number of casualties with minor contusions and abrasions were treated and dismissed. Smoke inhalation victims were given emergency treatment here and then admitted directly to the wards. All patients in shock or with lacerations were transferred to the emergency surgery. Fortunately we had no severe burns.

The emergency surgery station had four operating rooms off a main room
(Continued on Page 142)

**Since we can't teach employees
unless they want to learn,
it is essential to know**

How to Make Training Programs Effective

EDMUND MOTTERSHEAD

Mottershead Associates, Chicago

EMPLOYEE training in the past decade has taken on a kind of magic aura so that some men in management have come to feel that they can accomplish almost anything simply by starting another "training program." The fact of the matter is that training, as such, without motivation on the part of the trainee accomplishes little or nothing. In a literal sense, you can't "teach" anyone anything—you can expose him to the truth or knowledge or skill, but he must want to learn before any real learning can take place.

FOUR TRAINING OBJECTIVES

There are four basic training objectives facing the hospital management that wishes to "train" employees: (1) the development of good and effective attitudes toward the job, the hospital and the supervisors; (2) the passing on of a body of general and specific knowledge about hospitals in general, his hospital, his department; (3) the development of specific job skills, and (4) the nurturing of specific and desirable work habits.

1. *Attitude Training.* Attitude training implies the establishment of what constitutes a "desirable worker attitude." This may be stated specifically in terms of work quotas, attendance record, loyalty, punctuality, apparent competitive spirit, morale or other factors depending upon the situation and upon management's objectives.

Such training is basic to all others, not only because employees must want to learn in order for other training to be effective, but because the great majority of problems recognized by super-

visors fall into the category of employee attitude problems.

Matters such as apparent loafing, unwillingness to cooperate, tardiness, too much time out, absenteeism, excessive wasted time, excessive accidents, and a host of other cost-increasing factors can usually be traced to employee attitude—and, in turn, to supervision.

2. *Knowledge.* Knowledge is distinguished as what the worker should "know" apart from what he "does" or should do. He should know and understand certain matters of hospital policy, rules, regulations. He should know something of the hospital "business," of which he is a part. He should know something of his future with the hospital, something about its pension and bonus plans, and a host of similar factors. General knowledge of his trade or skill as apart from specific job skills is also part of the great body of information which it is usually desirable to convey to employees.

3. *Job Skills.* Specific job skills must usually be imparted directly on the job, even though the new employee comes to work fully competent and with previous experience in operating the type of equipment, or doing the kind of work being given him on the new job.

4. *Work Habits.* Even though the individual may have adequate skill in performing his job, his habits of work may be so sloppy or indifferent as to render his contributions unprofitable. Such work habits are a proper part of worker training both by formal programs and by daily supervisor, although the daily supervisory activity of his immediate boss is by far the greatest

factor in the individual's work habits. Matters such as safety, quality, precision, neatness, care in keeping material clean, care of work place, care of equipment, reporting of trouble promptly, tardiness, absenteeism, and over-all efficiency are all elements which can be put on the basis of good work habits.

TYPES OF TRAINING

Not every type of training is most effective in all situations or for all of these purposes. Orientation programs are most effective in beginning the development of worker attitudes; vestibule training programs are especially useful in providing basic equipment operating skills for hospitals which may have these skills and tools in wide use in many departments.

On-the-job training is effective in imparting both attitudes and specific job skills, but it suffers from its intermittent and catch-as-catch-can nature owing to interruptions which demand the time and attention of the supervisor.

Vocational school programs, both in the school away from the hospital and special courses which might be conducted on the job, have the advantage of providing skilled trainers or instructors who put across a particular body of information. But many times this information is not sufficiently related to specific jobs in the hospital.

Safety training as such cannot be separated from on-the-job skill training, as it usually involves instruction in the correct-and-safe way to do a job. However, there are usually other "haz-

Types of Training Programs for Employees and Common Objectives and Uses of Each

	ATTITUDES	KNOWLEDGE	JOB SKILLS	WORK HABITS
ORIENTATION	To develop attitudes toward job, hospital quality	Of company policy, rules. Of job hospital benefits		Explain standards of what constitutes a "good job" or a "fair day's work"
VESTIBULE	Toward quality and precision, cleanliness	Of basic job operations, the use of basic and special tools	Use of basic equipment, special skills	Carefulness, precision accuracy, cleanliness
ON-THE-JOB	Develop attitudes to job, department, supervisor	Of department, rules, operations, worker's place in over-all picture; basic methods used	Specific skills used in performing the particular job	Quality, accuracy, speed, standards, neatness, care of work place, maintenance
VOCATIONAL SCHOOL Courses—out of the hospital	Toward hospitals in general and local community	Technical or business subjects though usually not directly job-applied	Basic and specific machine skills; not necessarily job-applied	Basic habits of accuracy, quality, safety
VOCATIONAL SCHOOL Special courses in the hospital	Toward hospital	Technical or business subjects job-applied	Basic and specific skills job-applied	Specific habits of work, neatness, quality
SAFETY	Toward hazards, hospital, and supervision	Of job hazards	Skill in correct and safe job performance	Habits of safe workmanship
DAILY SUPERVISION	Attitude to hospital, job, supervisor	Of hospital and department, rules, processes, jobs, opportunities, conditions	Specific job skills	Habits relative to quality, neatness, punctuality, speed, efficiency, safety

ards" in the hospital besides those on the particular job, and both special programs and supervisory activity have a part to play in this type of employee training.

Daily supervision, in the last analysis is the largest part of the training any employee receives. The supervisor has a definite responsibility in this field which he discharges either consciously or not. If his actions and example are unplanned, his workers will develop certain attitudes, and will gain certain knowledge, acquire certain skills and work habits, some of which may not be entirely desirable from management's standpoint. If the supervisor is effective as a trainer, he is conscious of the four-fold training problem and aware of his every action as having some bearing upon the effectiveness of his training efforts.

Job instruction sheets of one sort or another are currently in use in many institutions placed prominently in the work place for the employee, so that there is a constant and specific reminder of what to do next, how to do it, and what quality or safety "key points" to watch for. Some of these sheets include drawings or diagrams.

Others are made even more visual with the use of photographs in series corresponding to the various job operations.

Handicapped workers are also benefited by the use of vestibule training, particularly where the training can be built around a particular type of handicap common to a group of such people hired. Men who have lost an arm or hand, for example, or blind people, can frequently be group-trained in basic job skills and job operations before actually being put to work on their own.

TARGET—METHOD—RESULTS

In beginning any employee training program, it has been found advisable to start one thing at a time. One specific operation's need to be met with training can be analyzed and a program can be developed and set into motion on a basis which permits evaluating results. Starting too many at once removes both much of the orderliness and much of the possibility of accurate cost analysis from the effort.

After the one program has been set up and got under way, it can readily be coordinated with other programs

which may also be in existence. Particularly, training programs should be coordinated with programs relative to safety, hospital rules, company policy, waste, absenteeism and suggestion system.

Management participation is essential to the effectiveness of any employee training. Not that top management must necessarily sit in on training sessions, but management must have an important part in planning and supervising the program, and should get periodic progress reports on results and costs saved. In the last analysis, the only question that hospital management is really concerned about is "Is the training program helping facilitate quality operations?" If your employee training is specifically set up to help specific operational problems, geared into other hospital programs, and with a basis provided for measuring results, you will find that it will help improve the whole hospital operation substantially. Training, though by no means a cure-all for human relations problems, can still be used intelligently as a tool for greater utilization of existing manpower and increasing productivity per man-hour.

Small Hospital Forum

By way of promoting good will

They Keep Patients Out of the Hospital

RICHARD O. WEST

Administrator
Norwalk Hospital
Norwalk, Conn.

DID you ever hear of a sales enterprise which attempted to create a customer's good will by discouraging the sale of its products or services? Hardly! As a matter of fact, such a practice would be considered not only economically unsound but suicidal from a business standpoint. Yet, that is exactly what Norwalk Hospital in Norwalk, Conn., is doing and with some success. It is a novel approach in public relations, which other hospitals might well adopt.

With the support of the public relations committee of the hospital's board of trustees, the residents of the community are being told how to "Take Good Care of Yourself" and stay out of the hospital. Six days a week, listeners of Station WNLK, Radio Norwalk, are being given helpful health hints, and once a week, newspaper readers in the area are given similar information in a column sponsored by the hospital.

IT'S GOOD PUBLIC RELATIONS

These series are a part of Norwalk Hospital's public relations program. The public's attention is focused on the fact that its hospital is really the center of all health activities in the community. The committee feels strongly not only that Norwalk Hospital should provide medical service for the ill but also that it would serve the interests of the community to a greater extent if it helped people to take better care of themselves and thus keep out of the hospital.

The five-minute radio programs are written by professionals in the area

who are interested in Norwalk Hospital. They donate their service both as writers and as the commentators who are actually heard on the air. The commentators are respected local citizens and their message attracts desired attention.

All of these programs are taped prior to broadcast time through the facilities of Station WNLK, which are donated for hospital use as a public service.

Going hand-in-hand with the radio series is a weekly newspaper feature of the same title. The Norwalk area is fortunate enough to be served by several weeklies as well as daily papers. Norwalk Hospital has been successful in gaining the cooperation of these newspapers. On the other hand, the newspapers are getting, free of charge, an excellent feature done by some of the best writers in the New York area. Here again, the writers' efforts were given with no thought of payment. They are public-spirited men who give their time and efforts freely. In order to make the hospital feature distinctive, the art department of a New York advertising agency designed an attractive mast to go with each feature. Both a single and a two-column cut are used by the various newspaper editors for their convenience when faced with space problems.

For both the newspaper and radio features, much care is taken to make

certain they are technically correct. The chief of staff of Norwalk Hospital reviews all copy for accuracy of fact.

Both features avoid assuming the rôle of doctors. They don't presume to diagnose. They consider subjects on a broad basis. They attempt to remind and inform people that following certain accepted health rules will help them to keep healthy and out of the hospital. Such subjects are covered as the common cold, tachycardia, obesity and staying sober when one has to drive.

WRITTEN FOR LAYMEN

It should be stressed that these features are written strictly on a lay level. They are written in a homey, conversational tone, and are frequently anecdotal. The newspaper feature is written succinctly, and averages approximately 200 words.

While we were planning for the radio series, we considered a 15 minute program. However, it was decided that it was difficult to hold audience attention through a straight commentary of that length, and the shorter program was agreed upon.

Next it was decided to run the five-minute program three days a week. The time of 11:55 a.m. to 12 noon was arrived at after consultation with the management of the local station. After a few months of successful operation, the committee decided to step up the broadcasts to six days a week, Monday through Saturday, at the same time. At this writing, this is the program schedule.

Immediate reaction has been favorable. Requests have been received for copies of the radio scripts. What Norwalk Hospital hopes to realize through its entire public relations program, of which these series are a part, is community good will, understanding and support.

All hospitals strive for the goals of public understanding, sympathy and appreciation. But before these goals can be reached, the public must be aware of its hospital. Aggressive public relations is trying to establish the hospital not just as a place to go in time of specific need but as an integral

part of the community, responsible to everyone and everyone's responsibility.

The public relations committee feels that helping people to stay away from the hospital doors is a striking departure from usual business procedure. In effect, Norwalk Hospital is saying don't buy our product, and what's more, it is telling people how they can avoid the necessity of buying it. This, coming from the fifth largest industry in the country, must indeed seem to the public to be an unusual departure from generally accepted business practices.

Norwalk Hospital feels that these series are productive adjuncts to their regular public relations program. Perhaps there are other hospitals which feel that one or both series may be suitable in their own particular situation. With that possibility in mind, Norwalk Hospital is prepared to share the experience it has gained through its own program, and also the professional talent which it is so fortunate to have at its disposal, with other hospitals. We believe that whatever may raise the esteem of hospitals in general will also be beneficial for Norwalk Hospital.

The florist joined the faculty to give

A Lesson in the Care of Flowers

SENIOR nurse's aides at Evanston Hospital, Evanston, Ill., had their training supplemented with an unusual demonstration recently, when Jack Sorbin, owner of Evanshire Florists, gave a program on the care and arrangement of flowers. About 100 student and graduate nurses and guests joined the senior nurse's aides for the presentation, called "Symphony in Flowers."

Mr. Sorbin brought to Patten Memorial Auditorium masses of roses, tulips, gladioli, sweet peas, daisies, chrysanthemums, acacia, and even a number of orchids. As he discussed methods of handling and arranging the various types, his assistant, Henry White, deftly combined certain flowers into unusual bouquets for men, children, new mothers, or bouquets for special occasions, or elaborate and simple corsages. He stressed technics of cutting and preserving flowers, and the use of such unusual containers as

EMILY WITHROW STEBBINS

Public Relations Department
Evanston Hospital
Evanston, Ill.

beer mugs, old-fashioned casters or peanut butter jars.

As a climax to the evening, Mr. Sorbin awarded the bouquets and corsages to members of the audience.

Guests of honor, the senior nurse's aides are a new group of ancillary

workers at Evanston Hospital who have been trained to do a large percentage of regular floor nursing duties under the supervision of graduate nurses.

Mr. Sorbin's program provided a stimulating, colorful evening of entertainment, many agreed, and also prepared them to care for patients' flowers more expertly when the occasion demands.



The florist presents a student nurse with a bouquet he has prepared during the flower demonstration held at Evanston Hospital, Evanston, Ill.

About People

Administrators

Dr. Joseph C. Hinsey, dean of Cornell University Medical College, has been appointed director of the Joint Administrative Board of the New York Hospital-Cornell Medical Center. Dr. Hinsey will succeed **Dr. Stanhope Bayne-Jones**, for the last six years president of the Joint Administrative Board of the Center. Dr. Bayne-Jones retired on June 30 to accept the position of civilian technical director of research of the Army Medical Research and Development Program. Dr. Hinsey will be responsible for the formation of policies and an over-all program for the Center.

Dr. Hinsey went to Cornell University Medical College in July of 1936 as professor of physiology and head of that department. In 1939, he succeeded the late **Charles R. Stockard** as professor and head of the department of anatomy, which responsibility he has continued to hold since his appointment as dean of the medical college in 1942.

Dr. Hinsey served as president of the Association of American Medical Colleges in 1950 and has been chairman of its executive council since 1947. He is a trustee of the Sloan-Kettering Institute and the China Medical Board and a member of the board of managers of Memorial Hospital. Since 1942, he has served as a faculty representative on the board of trustees of Cornell University. He is associate dean of the university's graduate school. Dr. Hinsey served on the Committee on the Survey of Medical Education, which was jointly sponsored by the American Medical Association and the Association of American Medical Colleges in 1948-53, and as a commissioner on the President's Commission on the Health Needs of the Nation in 1952.

Harold L. Hutchins Jr., formerly assistant director of Aultman Hospital, Canton, Ohio, resigned to accept the position of director of Pittsfield General Hospital, Pittsfield, Mass., succeeding



Dr. J. C. Hinsey

Dr. R. J. Marcotte. Mr. Hutchins' duties at Aultman have been assumed by **Henry B. Kidder**. Before going to Aultman, Mr. Kidder had been director of Athol Memorial Hospital, Athol, Mass. He attended Yale University in 1948 and 1949, where he earned his master's degree in hospital administration. His administrative residency was served at the New England Medical Center, Boston.

Jay G. Coberly has been appointed administrator of Oakbourne Colony Hospital, West Chester, Pa. He is currently business manager of the Children's Hospital of Philadelphia, and will move to West Chester in September.

Edward Lincke, formerly administrator of Massillon City Hospital, Massillon, Ohio, has been named to a similar position at Lincoln County Memorial Hospital, Troy, Mo.

Dr. George L. Wessels has resigned as superintendent of the Allegheny General Hospital, Pittsburgh, effective August 1, after serving in that capacity for the last 15 years. His interest in the hospital field brought him into various associations, among which were the American Medical Association, the Southwestern Hospital Conference (now the Hospital Conference of Pittsburgh), which he served as president, the Hospital Association of Pennsylvania, the American Hospital Association, and the American College of Hospital Administrators.

Thomas E. Tonkin has been appointed administrator of the University of California's Ernest V. Cowell Memorial Hospital, Berkeley, Calif. He was formerly on the staff of the Commission on Financing of Hospital Care in Chicago and North Carolina. Mr. Tonkin succeeds **Jack M. Scollard**, who has become assistant director of the Sacramento County Hospital, Sacramento, Calif.

P. Godfrey Savage has resigned as director of the Niagara Falls Memorial

Hospital, Niagara Falls, N.Y., a position he had held since 1922. **Howard R. Taylor**, assistant director since February 1950, and who has been serving as acting director, will take over the position of director. Mr. Savage is a past president of the Hospital Association of New York State and a fellow of the American College of Hospital Administrators. Mr. Taylor received a master of science degree in hospital administration from Columbia University in 1947 and served his administrative internship at Johns Hopkins Hospital, Baltimore, where he remained on the staff until 1950. He is a member of the American College of Hospital Administrators and the American Hospital Association.



Jay G. Coberly

Robert D. Stout

has been appointed assistant administrator of the Lutheran Hospital of Maryland, Baltimore. He served his administrative residency at the University Hospital, Baltimore. Recently he completed a tour of duty in the U.S. Army Medical Service Corps. Mr. Stout holds a membership in the American Hospital Association.



Robert D. Stout

Robert M. Schnitzer

Schnitzer, director of Middlesex General Hospital, New Brunswick, N.J., has been chosen by the Hospital Service Plan of New Jersey to fill the newly created position of assistant director in charge of hospital relations. Mr. Schnitzer had been at Middlesex for the last year and a half. He is a member of the American College of Hospital Administrators and holds a master's degree in hospital administration from the University of Chicago. He has also been a member of the A.H.A.'s council on hospital service plans and chairman of the accounting committee.

(Continued on Page 184)



R. M. Schnitzer



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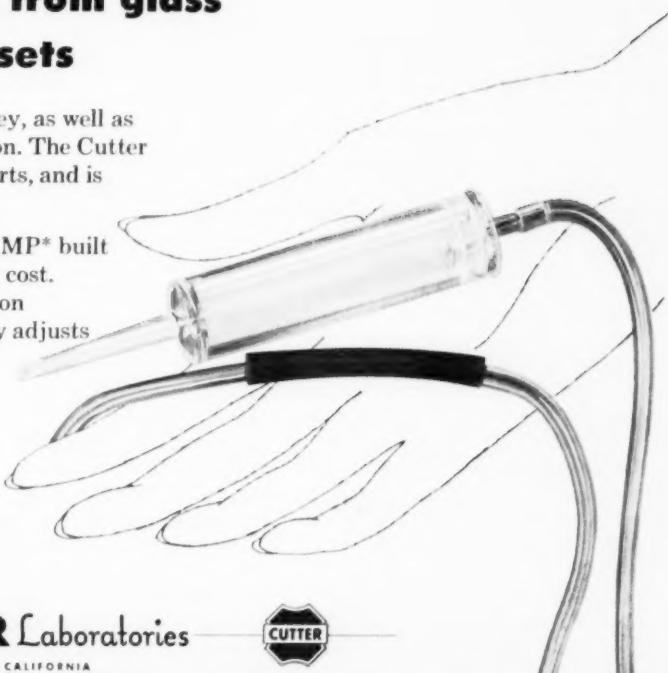
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What Is Happening to Special Hospitals

LOUIS BLOCK, Dr. P.H., and JOSEPH P. PETERS

Division of Medical and Hospital Resources, Public Health Service, Washington, D.C.

MENTION the term "Special Hospitals" and usually the response is "They are on their way out." Is this statement true? What are the facts? What do they tell us about the happenings in the special hospital picture? What is the present rôle of these hospitals in the total medical activities of the nation? What about the future? And most important of all, how does the patient fit into this picture?

A considerable amount of factual and statistical information is available about the past and present rôle of special hospitals. Indeed, what has happened during the past two decades should give us a good idea of what will probably take place in the near future. This appeal to facts can lead to more effective planning and coordination of special hospitals in tomorrow's program for better health for everyone.

1. What Is a Special Hospital? Special hospitals include a miscellany of organized medical care institutions dedicated to treating specific disease conditions or limited to special groups (such as women or children). Although tuberculosis and mental hospitals immediately fall into this category, their problems and activities are somewhat different from those of what common usage has termed a special hospital. The large number of these institutions, plus the tremendous number of beds they provide in the national picture, requires that they be treated separately.

For this particular discussion, the classification employed by the American Medical Association in its annual

Hospital Number will be used. Herein are included maternity, eye, ear, nose and throat, children's, orthopedic, industrial, convalescent and rest, and isolation.

2. A Glimpse at the Past. Special hospitals date back to antiquity. History records special institutions dedicated to the care of maternity patients as early as 610 A.D. Institutions for epileptics, isolation hospitals for the relief of venereal disease victims, and special houses for the refuge of the blind sprung up in various parts of Europe during the Fifteenth and Sixteenth Centuries.

Even more than general hospitals, these specialized institutions are a sensitive barometer of the rise and fall of different patterns of disease and of the methods of coping with them. For example, hospitals organized for the care of lepers and of victims of the plague were particularly prevalent during the middle ages, when these diseases ravaged Europe. The worldwide move to establish more eye hospitals in the first half of the last century, to cite another instance, has been attributed to the widespread ravages of granular ophthalmia or trachoma during that period.

These early forerunners were quite unlike the special hospital of today. But, for that matter, neither were the hospitals of that period exact counterparts of the modern general hospital with which we are familiar.

With the growth of specialization, the widespread development of the medical sciences, and the increasing recognition of need for such services during the Nineteenth Century, large

numbers of special hospitals of all types emerged throughout Europe and the United States. L'Hôpital des Enfants Malades in Paris, dedicated to treating acute illness among children, commenced its activities in 1802. The New York Nursery and Child's Hospital was established in 1823 and a similar institution was founded in London a few decades later. London had the first special hospital for eye and ear conditions with the opening of the London Infirmary for curing diseases of the eye and ear in 1805. The National Eye Hospital was started in Dublin in 1814. Other famous institutions established during this period include Women's Hospital in New York (1855), the Boston Lying-In Hospital (1832), the Royal Dental Hospital in London (1858) and the National Hospital for the Paralysed and Epileptic (1859).*

The theory behind the approach of special hospitals was that a higher degree of efficiency and better quality of care could be attained in such institutions. In addition, teaching, study and research, it was believed, flourished in this atmosphere. In appraising the why and wherefore of such institutions, one should not overlook the fact that, more often than not, existing general hospitals were either not interested or not prepared to establish adequate separate departments to care for patients requiring such specialized services. Even today this situation often exists, particularly in the area of cancer and allied diseases.

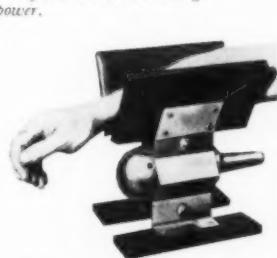
* Sand, René: *The Advance to Social Medicine*. New York: Staples Press, 1952. Pp. 83-85

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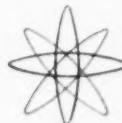


Table 1—Relationship of Rank by Size of State According to Population (Based on 1951 Population Estimate) to Special Hospitals and Special Hospital Beds, Ranked According to Numbers.

State	Population Rank	Rank by No. of Special Hospitals*	Rank by No. of Special Hospital Beds
New York.....	1	1	1
California.....	2	4	5
Pennsylvania.....	3	3	3
Illinois.....	4	2	4
Ohio.....	5	7	10
Texas.....	6	5	7
Michigan.....	7	8	12
New Jersey.....	8	6	2

*Mental and tuberculosis excluded.

3. Some General Characteristics of the Modern Special Hospital.

Today most special hospitals are characteristic of large metropolitan centers. By their very nature they require a fairly large supply of specialists in their particular fields. A large population is essential either in the immediate area in which the hospital is located or in readily accessible hinterland. Table 1 illustrating the fact that the eight states with the largest populations are also those which have the

greatest numbers of special hospitals and, for the most part, the largest number of such beds, vividly proves this point. This must be so as only a relatively small percentage of persons hospitalized for all causes require, for example, specialized eye or cancer services. Isolation and maternity hospitals are perhaps exceptions, but even they require a larger population group than does the general hospital.

Generally speaking, one rarely finds special hospitals springing up in areas

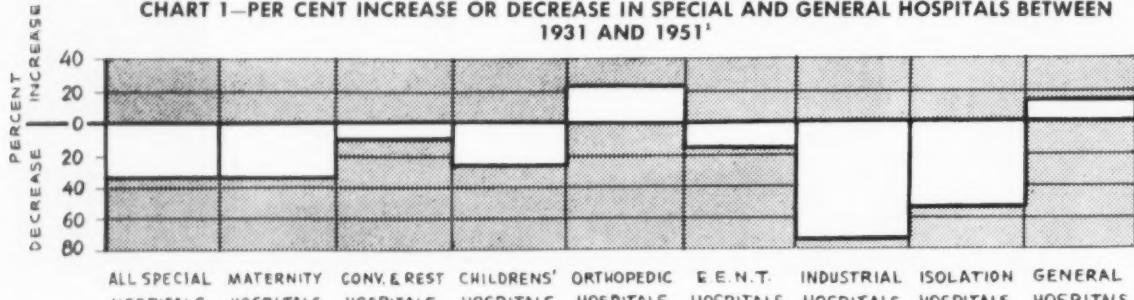
where patients are receiving these services adequately in existing general hospitals. One wonders what the history of these hospitals would have been, had the general hospital of yesterday been more truly general.

There are 461 special hospitals of varying sizes and types scattered throughout the United States; 68 per cent of these special hospitals are located east of the Mississippi River. Indeed almost a quarter of the total national number is located in the tri-state area of New York, New Jersey and Pennsylvania.

More than half of all the special hospitals located west of the Mississippi are found in California, Texas and Missouri. Three states have no special hospitals, while 21 other states have fewer than five. Most of these are in the plains and mountain states.

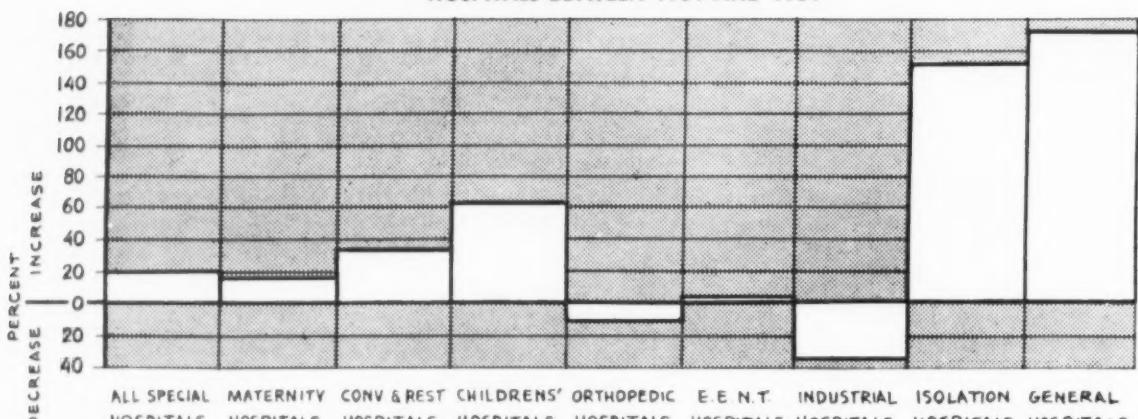
Of the 38,536 special hospital beds in this country, almost 75 per cent are located east of the Mississippi River. Again, almost a third of the total national number is centered in the tri-state areas of New York, New Jersey and Pennsylvania. In fact, these three

CHART 1—PER CENT INCREASE OR DECREASE IN SPECIAL AND GENERAL HOSPITALS BETWEEN 1931 AND 1951¹

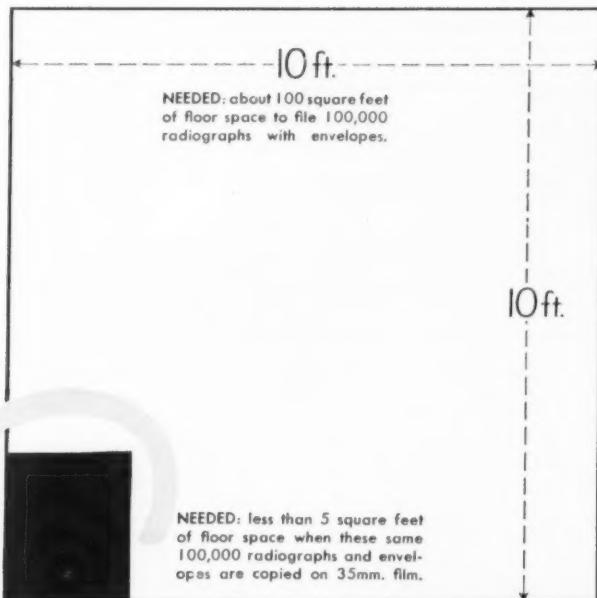


¹Computed from data in annual hospital numbers, Journal of the American Medical Association.

CHART 2—PER CENT INCREASE OR DECREASE IN ADMISSIONS TO SPECIAL AND GENERAL HOSPITALS BETWEEN 1931 AND 1951²



²Computed from charts in annual hospital numbers, Journal of the American Medical Association.



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Table 2—Special Hospitals³

Type	Hospitals		Beds		Admissions		Average Census	
	1931	1951	1931	1951	1931	1951	1931	1951
Maternity.....	145	90	8,078	4,632	91,946	105,663	4,737	2,953
Conv. and Rest.....	133	120	6,123	7,115	28,628	38,057	4,429	5,078
Children's.....	60	44	5,463	5,133	83,416	135,043	3,823	3,438
Orthopedic.....	68	82	6,569	6,708	37,842	33,009	5,131	5,209
E. E. N. T.....	64	53	2,774	2,595	113,762	114,516	1,444	1,502
Industrial.....	142	32	6,476	2,837	93,415	60,951	3,118	1,890
Isolation.....	86	40	7,603	9,516	40,210	101,026	2,837	5,097
Total.....	698	461	43,806	38,536	488,769	588,265	25,519	25,167
Type	Percentage of Occupancy		Length of Stay (Days)		Average Size of Hospital		Admissions per Bed	
Maternity.....	59	64	19	10	56	51	11	23
Conv. and Rest.....	72	71	56	49	46	59	5	5
Children's.....	70	67	17	9	91	117	15	26
Orthopedic.....	78	78	49	58	97	82	6	5
E. E. N. T.....	52	58	5	5	43	49	41	44
Industrial.....	48	67	12	11	46	89	14	21
Isolation.....	37	54	26	18	88	238	5	11
Average	59	65	19	16	62	84	11	15

³Computed from data in annual hospital numbers, *Journal of the American Medical Association*.

states rank 1, 2, 3 nationally, in their numbers of special hospital beds. Some states which have relatively large numbers of such beds and which are not shown in Table 1 are: Missouri (1436 beds), Georgia (1420 beds), and Arkansas (1245 beds). Arkansas' large number of beds is somewhat distorted, however, owing to the 900 bed U.S.-P.H.S. medical center for venereal diseases located in Hot Springs. A similar situation exists in the state of Mississippi where all 775 of the special hospital beds are found in two state controlled medical centers for the treatment of venereal diseases.

4. Trends. The compilation of data over a period of time permits the establishment of trends in the development of a program, project or activity. Although statistical information is historical because it tells us what has already happened, it is only by observing trends indicated by such data that we are able to estimate with any degree of accuracy what may be expected in the future.

Detailed statistics on activities in special hospitals are available since 1931. Even in this relatively short period of 21 years (between 1931 and 1951) certain basic trends are evident. Table 2 and the accompanying charts emphasize what is taking place.

5. Special vs. the General Hospital. How do these trends in special hospitals compare with corresponding trends in general hospitals?

Special hospitals have, as a group, declined in numbers. This decrease occurred during a period when general hospitals increased by 13 per cent. The picture is even more marked in regard to numbers of beds. Beds in special hospitals evidenced, as we have already noted, an 11 per cent decrease, while general hospital beds increased almost 67 per cent. The same situation occurred with regard to the number of bassinets.

The number of patients admitted to special hospitals, although showing an increase, in no way came near to the tremendous increment in general hospital admissions. Average daily census in the specialized institutions showed no appreciable change; but in the general hospital there were large gains. Percentage occupancy, on the other hand, showed remarkable similarities between the two groups.

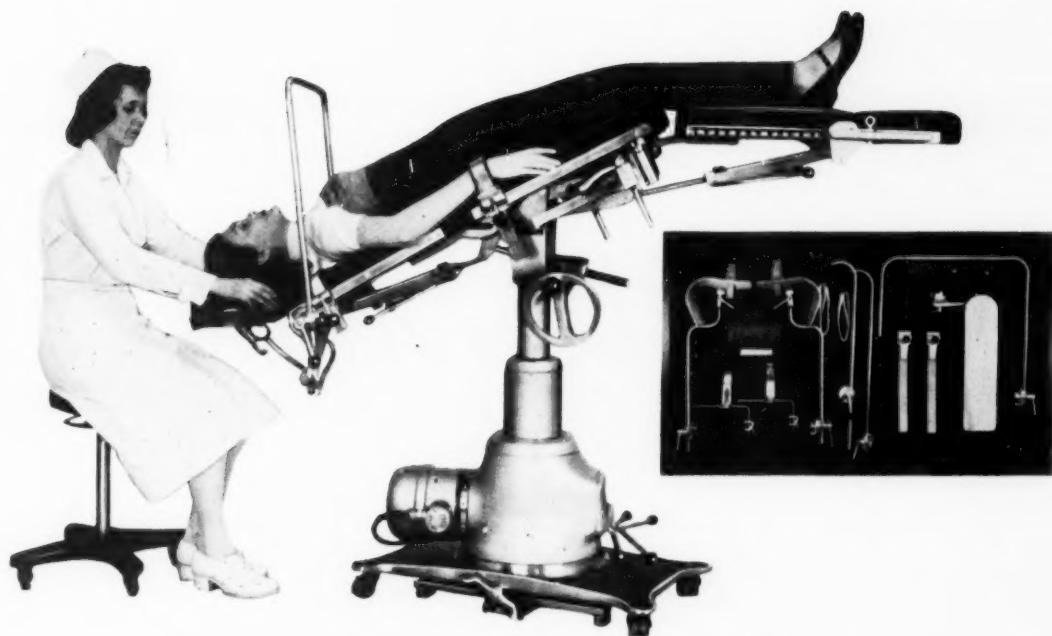
Both groups of hospitals have grown in average size. The average general hospital has increased in size from 89 to 131 beds during the two decades between 1931 and 1951. In the same period special hospitals increased from 62 to 84 beds.

The past few decades have been characterized by remarkable drops in the average length of patient stay in hospitals. The financial, psychological and social implications of this development can scarcely be overemphasized. When one scans the monumental achievements of medical science and

the application of this hard-wrested knowledge to everyday hospital practices, the picture is even more impressive. These gains have taken place in all types and sizes of hospitals, the special hospital being no exception.

With people staying in hospitals for a shorter period of time and paralleled by an over-all increase in annual admissions, it is anticipated that an increase in the average number of admissions per bed per year would result. Annual admissions per bed increased from 11 to 15 in the special hospital classification and from 16 to 27 in general hospitals during the last two decades.

What does all this mean? Simply that the special hospital still plays an important part in the total medical care picture. However, the general hospital, as it becomes more truly general, has made great inroads into the areas formerly covered by specialized institutions. Indeed there is a growing trend to absorb special hospitals into large medical centers and to establish special departments in general hospitals. In addition, this tendency has also included the establishment and construction of even proportionately fewer special hospitals. Such integration is a logical extension of the growing trend toward combining all hospital and medical functions into one coordinated medical organism comprising all curative, preventive and restorative services.



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Artificial Kidney Is a Lifesaver

JOHN E. KILEY, M.D.

Albany Hospital, Albany, N.Y.

THOMAS HALE Jr., M.D.

Director, Albany Hospital, Albany, N.Y.

IN THE spring of 1949 Albany Hospital, Albany, N.Y., decided to establish an artificial kidney unit as part of the general diagnostic and treatment facilities. We were aware that it might be some time before we could hope to operate such a unit on a break-even basis, but we felt that with a potential patient population of well over 2,000,000, there would be enough demand for an artificial kidney to warrant its inclusion in our diagnostic and treatment armamentarium, and we hoped that it would eventually pay for itself. At that time there were fewer than

six artificial kidneys in operation throughout the country. Because of our relative proximity to Boston and because the Peter Bent Brigham Hospital had done a great deal of the pioneer work in this field, we felt we could benefit by sending someone to Boston to study the mechanics and operation of the kidney which was in use there. At the same time we ascertained that a similar kidney, somewhat modified in design, could be built for about \$3,000, and we placed our order with the understanding that it would be several months before this kidney would be

ready for delivery. The various parts of this machine are shown in Figures 1 and 2.

One of our assistant residents in medicine was then chosen to spend eight weeks in Boston at the Peter Bent Brigham Hospital working with the doctor-nurse team charged with the responsibility of operating the artificial kidney. When he returned to Albany he spent many hours teaching two nurses who volunteered for this assignment to perform the functions they would be called on to exercise in the actual operation of the machine. A suitable location was chosen, and rather extensive alterations were made to provide the proper fixtures and drainage for the kidney.

The room to house an artificial kidney must be clean, well lighted, well ventilated, and must be of sufficient size, probably not smaller than 15 feet by 17 feet in dimension. A floor drain not less than 2 inches in diameter is needed for the rapid emptying of the 100 liter bath, and a mixing valve with



Fig. 1—Photograph of artificial kidney at Albany Hospital.¹

¹Wolf, A. V.: Science, 115:193-199, 1952.

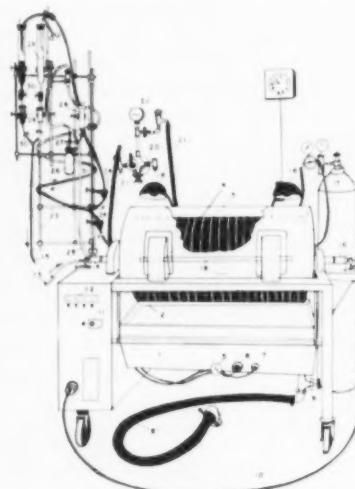


Fig. 2—Diagram for identification of parts²

²Wolf, A. V.: Science, 115:193-199, 1952.

1. Reservoir for bath	16. Rotation coupling
2. Water level and reservoir	17. Gas tank
3. Rotating drum	18. Lights
4. Cellophane loops	19. Hood
5. Thermometer	20. Water mixing valve for filling bath
6. Light	21. Hose for filling bath
7. Thermostat	22. Thermometer
8. Draining hose	23. Frame
9. Draining valve	24. Tubing elevating blood to inflow reservoir
10. Power cable	25. Pump tubing
11. Switch for elevating or lowering bath	26-27. Pump control
12. Control panel	28. Inflow reservoir
13. Intake tubing from artery	29. Filters
14. Rotation coupling	30. Control clamps
15. Tubing leading to vein	31. Blood-air interface



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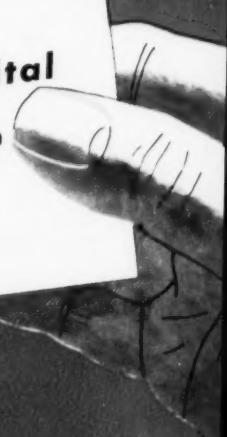
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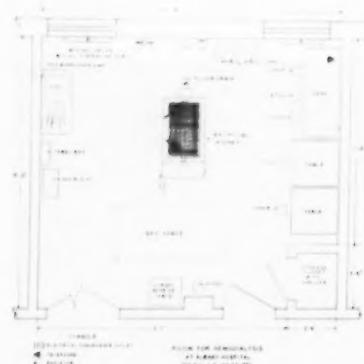


Fig. 3—Floor plan of artificial kidney unit at Albany Hospital, Albany, N.Y.

thermometer for filling the bath with water at approximately body temperature is necessary. Ninety-five per cent oxygen and 5 per cent carbon dioxide for solution in the bath water must be available, and in addition, a sink, a hot plate, chairs and tables are needed to complete the essential equipment. A diagram of the room used at Albany Hospital with the placement of the fixtures is shown in Figure 3.

The basic idea in hemodialysis is a simple one, consisting of the passage of a stream of the patient's blood through a very large volume of solution containing, in the proper concentration, most of the important chemical constituents of interstitial body fluid. This solution and the blood are separated by a membrane which allows free dialysis of many chemical compounds between blood and solution, but which prevents either loss of blood cells and proteins into the solution or invasion of the blood by infectious organisms from the solution.

This arrangement is brought about by the Kolff type of kidney as shown in Figure 4. In essence, blood is taken from the patient's radial artery via a cannula and is then conducted in plastic tubing through a rotation coupling into the cellophane loops which are immersed in the bath fluid and serve as the dialysing membrane. The rate of blood flow and volume of the bath are such that by the time the blood has reached the end of the cellophane tubing the chemical abnormalities have been largely corrected. In uremia, for example, the elevated N.P.N., the high urea concentration, high values of organic acids, phosphates, sulfates, high potassium concentrations, and other abnormal biochemical elevations are

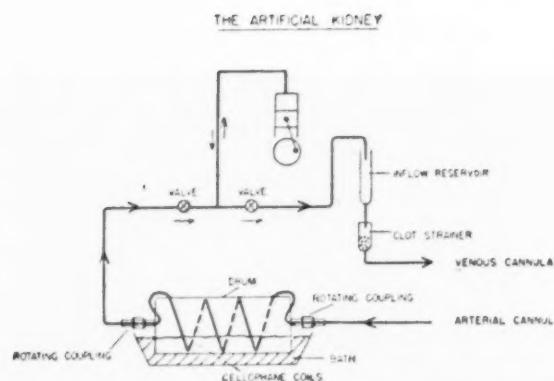


Fig. 4—Diagram of essential features of the artificial kidney.³

Merrill, J. P., Thorn, G. W., Walter, C. W., Callahan, E. J., and Smith, L. H.: *J. Clin. Investigation* 29:412-424, 1950.

reduced to values near normal. Simultaneously, the low chloride, low bicarbonate, low calcium and similar deficiencies are restored. The blood, now normal biochemically, continues out through the second rotation coupling, around the machine, and is pumped into a reservoir from which it runs back down into a forearm vein in a manner exactly analogous to blood transfusion technic. A chart showing chemical changes in the blood of an actual patient treated at Albany Hospital is shown in Figure 5.

The artificial kidney finds its greatest usefulness in connection with severe renal failure. In those cases where there is a shutdown of renal function owing to shock, intercurrent infection, or some other cause of a temporary nature, the artificial kidney may tide an individual over a period of anuria which might otherwise prove fatal, and thus restore to health a person whose life would otherwise have been lost. In cases where there already exists serious

renal damage of a progressive or non-reversible nature, the artificial kidney frequently affords marked temporary relief, thus prolonging life in some cases and increasing the comfort of the patient for considerable period of time.

The most important feature of the artificial kidney is the apparent fact that not only is the patient biochemically corrected, but the clinical state of the patient is often improved. If the patient is comatose or stuporous at the start, he may be awake and alert before the end of the run. If the patient is not in such serious condition at the start, the day after hemodialysis he usually volunteers that he feels a "great deal better," as though "a great weight has been lifted from my shoulders," or "best I have felt in a long time." So one can say that the artificial kidney corrects both the biochemical abnormalities and the clinical manifestations resulting from these biochemical abnormalities.

In addition, the artificial kidney may be utilized in some cases of intoxication to remove rapidly from the body the offending drugs, as in instances of intoxication from acetylsalicylic acid and bromides. Here it may indeed be a life saving procedure.

Although the safety of hemodialysis has been amply demonstrated, it is well to note two hazards. First, since it is necessary to heparinize the patient to prevent the clotting of blood in the machine, it would be unwise to carry out hemodialysis in the face of active bleeding. Second, since a moderate elevation of blood pressure may occur during hemodialysis, the consequences of this increase in blood pressure must be carefully considered.

The initial outlay which a hospital

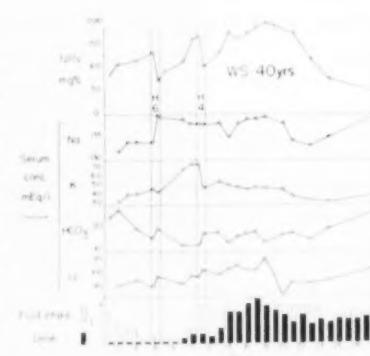


Fig. 5—Chart of chemical changes in case of W. S.

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must be prepared to meet in order to inaugurate a hemodialysis unit is represented by approximately \$3000 for the purchase of the kidney itself, plus the expense of sending a qualified physician to learn the operation of the kidney at a hospital where it has already been established. The cost of preparing the room would depend on the space available and the alterations necessary and would differ in each hospital.

The treatment itself lasts about six hours. Preparation of the room and kidney unit involves three hours of the time of three people, and during the

Experience With Artificial Kidney

	No. of Pts.	No. of Treatments	Income	Expense	Profit or Loss
1951	11	18	\$2,235.74	\$3,335.34	-\$1,099.60
1952	19	27	3,968.89	2,715.38	+\$1,253.51

treatment two nurses must be in attendance. At the conclusion of this period, eight hours of nursing time are necessary to clean up and prepare for the next treatment. It is thus apparent that each treatment involves 20 hours of nursing time, and 16 hours of a qualified physician's time. It is, of course, essential to have the entire team

available on a moment's notice because of the emergency nature of some cases.

It is difficult, if not impossible, to establish a schedule of charges which exactly represents the cost of giving the treatment. In the beginning, we followed rather arbitrarily the schedule in use in some of the other hospitals which had preceded us with a hemodialysis unit. Our charges per treatment are as follows: private, \$200; semiprivate, \$150; ward, \$100.

Our experience with the kidney to date is shown in the accompanying table.

In 1951 about 30 per cent of the patients were benefited in that they either appeared cured or were able to leave the hospital and have been active for at least six months. In 1952, with increased experience in selection of cases, about 50 per cent of the patients were so benefited. Inasmuch as hemodialysis was not used unless it was believed that death might occur if the artificial kidney was not employed, these percentages are gratifying.

Although the artificial kidney will improve temporarily an illness in which altered body biochemistry plays a major rôle, whether because of kidney failure, vomiting, poisoning or some other cause, the improvement produced by hemodialysis is in the nature of a respite, so that the final result is determined by whether or not the underlying disease is self-limited or can be arrested before organs essential to life are irreversibly damaged. In the complete absence of kidney function, life cannot be maintained indefinitely by hemodialysis. For that reason, in a disease such as chronic glomerulo-nephritis, when practically no kidney function remains and no way is known of arresting the disease, hemodialysis offers only temporary symptomatic relief and there is probably little justification for its use save in exceptional circumstances. Before the terminal stage is reached, however, hemodialysis may be of great worth to the patient with diminished kidney reserve in tiding him over an attack of severe gastro-enteritis, an essential operation, or some similar temporary stress to kidney function. And in disease states in which the basic process is self-limited or reversible, hemodialysis may well be life saving.

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Watch Those Antibiotics!

Prophylactic administration of drugs in surgical cases has its hazards

FRASER D. MOONEY, M.D.

Director, Buffalo General Hospital, Buffalo, N.Y.

DURING April of 1952, within a period of 17 days, five patients in the Buffalo General Hospital, Buffalo, N. Y., developed severe diarrhea. Each of these patients became seriously ill, two of them dying within 36 hours after the onset of the diarrhea.

A thorough investigation was made by a team, consisting of the chiefs of the medical, surgical and gynecological-obstetrical services, the chief pathologist, bacteriologist, chemist and the director of the hospital.

The following pattern was noted in this group of patients, as well as in four others who recovered without serious complication because of early and heroic treatment: (a) all patients were surgical cases; (b) the surgery had been elective in type, rather than emergency, and, hence, (c) all patients had been thoroughly prepared; (d) all patients had had one or more antibiotics; (e) all patients were over 45 years of age.

Case 1. Mrs. A. was operated on 24 hours after admission for conization of cervix, perineorrhaphy and ventral fixation. She was given terramycin, prophylactically, before the operation. Diarrhea commenced three days later; continued for four days, and gradually stopped under active supportive treatment, including intravenous therapy. She was discharged on May 3, 1952.

Case 2. Mrs. B. was operated on 24 hours after admission for a hysterectomy. She was given terramycin and forticillin, prophylactically. Diarrhea commenced three days later. She died on the fourth day.

Case 3. Mrs. C. was admitted and had an esophagoscopy performed on the same day. She had sulfadiazine and crystallin, prophylactically. Diarrhea

commenced two days later, and subsided under supportive therapy. She was discharged four days later.

Case 4. Mrs. D. was operated upon for repair of a hiatal hernia. She was given syncrobin, prophylactically. Diarrhea commenced two days after surgery. The patient died the next day, despite heroic treatment.

Case 5. Mr. E. was admitted and operated upon the same day for cholecystectomy. He was given syncrobin, prophylactically. Diarrhea commenced six days later, and the patient was extremely ill during this time. Supportive therapy included intravenous glucose and blood transfusions. The patient was discharged 10 days later, or 16 days following admission.

CASES IN OTHER HOSPITALS

We were informed that similar cases had occurred in other hospitals in Buffalo, and, on checking, found this to be correct in at least one of the hospitals, where one death occurred under similar circumstances. It was also found that in a hospital in a neighboring city, two deaths had occurred in the same manner, and within a short space of time. We communicated with the director of the other Buffalo hospital in which the death had occurred and we received his full cooperation.

Postmortem examinations of the three deceased patients revealed identical conditions. The normal intestinal flora, with the exception of *Staphylococcus aureus*, were absent throughout the entire intestine. The small bowel, usually sterile, was loaded with *Staphylococcus aureus* and no other bacteria. The wall of the small intestine showed ulcerations with a watery exudate similar to that seen in fatal cases of Asiatic

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cholera. The kidneys, spleen and other internal organs showed evidence of extreme toxic effects, sufficient to cause death. This was believed to have been caused by the toxins exuding from the overgrowth of *Staphylococcus aureus*. The *Staphylococcus aureus* was found to have resisted, and, in fact, to have thrived on all the antibiotics used.

The committee reached the conclusion that the following conditions were the causative factors:

1. The empty intestine, caused by the preoperative preparation, allowed the antibiotics a clear field to kill off

the normal intestinal flora, with the exception of the *Staphylococcus aureus*. The *Staphylococcus aureus*, in turn, having no other bacteria to combat in the battle of the "survival of the fittest" thrived and grew in enormous numbers.

2. Either the acid juices in the stomach did not do their normal job of killing off the bacteria ingested with the food, or else the *Staphylococcus aureus* lived through their passage through the stomach, because of its thriving on the antibiotics.

3. The shock of surgery lowered the

normal natural resistance of the patient.

In four of the five cases in Buffalo General Hospital, and in the one case in the other Buffalo hospital, the symptoms commenced on the second post-operative day, and in the sixth case, on the sixth postoperative day. The three deaths occurred within 24 hours.

At the completion of the investigation, a meeting was held consisting of the original team, together with the pathologist from the second Buffalo hospital, the county health commissioner, representatives from the two leading newspapers, and a member of the board of trustees of our hospital, who is the chairman of the public relations committee. We knew that such information as this could not and should not be kept from the public, and we realized that if we invited the press to sit in, it would get the correct story and would permit the hospitals to have some control as to the manner in which the information was presented in the papers. The results were excellent, and we were allowed to approve the final draft before publication.

The reason for bringing this to the attention of hospital administrators, particularly, is because of the fact that in most hospitals the director of nursing reports to the administrator each morning, and brings to his attention any unusual occurrences of the previous 24 hours. She would certainly report acute cases of diarrhea. In a large hospital, all such information is funneled into the director. He is probably the only person, with the exception of the director of nursing, who would become aware of such cases scattered throughout the hospital, and it would naturally occur to him that he should request an immediate investigation by the staff.

There was no doubt, in the considered opinion of the committee, that the antibiotics were the causative agent. It was realized, of course, that these same antibiotics had saved thousands of lives, and their use could not be dispensed with. Nevertheless, the committee came to the conclusion that discrimination should be used in prescribing antibiotics, particularly prophylactically. When any slight diarrhea occurs in such cases, the administration of such antibiotics should be stopped immediately and active supportive therapy begun.

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Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

NOREPINEPHRINE

HISTORICAL

FOLLOWING a description by Thomas Addison in 1855 of the anatomy of the adrenal gland in healthy and diseased states, physiologists were prompted to determine its functions. Brown-Séquard (1856) noted that extirpation of the adrenal glands in laboratory animals resulted in their death within a short period of time. Oliver and Schäfer (1895) confirmed this finding and studied the effects of extracts of adrenal glands of the calf and of other animals. In all species examined (dogs, cats, rabbits and guinea pigs) injections of the extracts produced a marked rise in blood pressure; section of the vagi or the pretreatment of a dog with atropine markedly enhanced this pressor effect. Limb blood flow and kidney volume, measured with plethysmographs, generally showed a decrease in volume; in the frog, the authors observed marked constriction of the arterioles. Separate extracts of the adrenal cortex and medulla were made, and it was demonstrated that the pressor fraction resided in the medullary portion of the gland.

Following the publication of the results of Oliver and Schäfer, the pressor fraction of the adrenal gland was obtained in relatively pure form and its structure was elucidated (Abel and Crawford, 1897; Fürth, 1900; Takamine, 1901, and Aldrich, 1905). The compound was termed suprarenin by Fürth (1901), adrenalin by Takamine (1901), and epinephrine by Abel (1902). Following the synthesis of epinephrine and its congeners by Stoltz (1904) and Dakin (1905), a method was evolved to separate racemic mixtures (Flächer, 1908). The *d*-tartaric acid salt of *dl*-epinephrine was extracted with methyl alcohol, in which *d*-epinephrine-*d*-tartrate was soluble and *l*-epinephrine-*d*-tartrate insoluble.

CHEMICAL STRUCTURE AND POTENCY

Barger and Dale (1910) tested a large series of primary and secondary aliphatic and aromatic amines for sympathomimetic activity, comparing the potency primarily on their ability to inhibit the contractions of the isolated nongravid cat uterus and to increase the blood pressure of decerebrated cats. The compounds tested included: aliphatic amines of varying chain lengths and aromatic amines with (1) no phenolic hydroxyl groups, with (2) one, and with (3) two phenolic hydroxyl groups (catechol amines). Primary and secondary aliphatic amines possessed some sympathomimetic activity, although they were not as potent as the aromatic compounds. In general, the secondary aromatic amines were more effective than the primary compounds in inhibiting the contractions of the isolated cat uterus. The most potent compounds of all the amines studied were the primary amine, aminoethanolcatechol (*dl*-norepinephrine), and the secondary amine, methylaminoethanolcatechol (*dl*-epinephrine).

dl-Norepinephrine was about one and one-half times as potent as *dl*-epinephrine in producing a rise in blood pressure in the cat; however, *dl*-epinephrine was markedly more potent in inhibiting the contractions of the cat uterus. The authors concluded that the more a compound resembled the structure of epinephrine, the greater its pressor activity. They speculated that the true sympathetic effector substance might not be epinephrine, but rather a primary catechol amine, norepinephrine.

In an effort to explain the inhibitory and excitatory effects of epinephrine and sympathetic nerve stimulation on various animal preparations, Cannon and Rosenblueth (1933) hy-

pothesized that the mediator substance (epinephrine) combined with substances in the cells to form inhibitory and excitatory sympathin (sympathin I and E). Bacq (1934) suggested that the excitatory effects were due to the liberation of a substance similar to norepinephrine. Greer *et al.* (1938) suggested that epinephrine and norepinephrine had a direct effect on the reacting cells, one mainly inhibitory (epinephrine) and another mainly excitatory (norepinephrine), thus rejecting the theory of Cannon and Rosenblueth of two tissue sympathins.

OCCURRENCE IN TISSUES

Euler (1946) demonstrated the presence of a pressor substance in extracts of mammalian spleens and hearts which closely resembled arterenol (*dl*-norepinephrine) in both its biologic effects and chemical properties. It was also demonstrated that the same substance occurred in extracts of the splenic artery nerves of horses and cattle (Euler, 1946). Following the successful separation of *dl*-norepinephrine into its optical isomers by Tainter *et al.* (1948), Euler (1948) demonstrated that *l*-norepinephrine corresponded to the sympathomimetic substance present in adrenergic nerves both in biologic effects and colorimetric analysis.

METHODS FOR DETERMINATION

Following the elucidation of the chemical and physical properties of *l*-norepinephrine (Tullar, 1948), the compound was identified in adrenal glands (Bergstrom *et al.*, 1949 and 1950); it was also identified in U.S.P. standard "epinephrine" (Tullar, 1949; and Auerbach and Angell, 1949). U.S.P. epinephrine was estimated to contain between 10.5 and 18.5 per cent *l*-norepinephrine.

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A number of methods have been employed to estimate the amount of norepinephrine in extracts in which epinephrine is also present. When norepinephrine is oxidized with iodine, it produces a red color owing to the formation of noradrenochrome; epinephrine forms adrenochrome in this reaction, also producing a reddish color, but its oxidation proceeds at a faster rate than that of norepinephrine (Euler and Hamberg, 1949). This difference in the rates of oxidation has been utilized to determine the amount of norepinephrine in the presence of epinephrine. The difference of the intensity of fluorescence of epinephrine and norepinephrine in the presence of alkali and oxygen can also be used for estimation of norepinephrine (Lund, 1950). Paper chromatography as described by James (1948) and modified by Euler and Hamberg (1949) has been employed to separate and identify norepinephrine and epinephrine in tissue extracts. When a combination of biological preparations on which the potency of norepinephrine and epinephrine differ is used, the quantity of each substance in an extract can be estimated relative to an assay of pure solutions of the two drugs. The preparations commonly employed for this assay include: the blood pressure of spinal cats, on which norepinephrine is about twice as potent as epinephrine, and the isolated rat's uterus or the hen's rectal caecum, on which epinephrine is from 25 to 100 times as potent as norepinephrine (Euler, 1950; Büllring, 1950, and Gaddum *et al.*, 1949).

With the availability of *l*-norepinephrine and with the demonstration of its presence, as well as that of *l*-epinephrine, in adrenal glands, adrenergic nerve fibers, and in the extracts of mammalian spleen and heart, the actions of exogenous *l*-norepinephrine were studied in animals and man.

EFFECTS OF NOREPINEPHRINE IN MAN

Cardiovascular: Blood Pressure. The effects of norepinephrine on blood pressure have been studied and compared to those of epinephrine by a number of investigators (Goldenberg *et al.*, 1948; Swan, 1949, and Judson *et al.*, 1950). Both norepinephrine and epinephrine produce a rise in the systolic blood pressure when administered by intravenous infusions (0.1–0.4 microgm./kgm./min.). Norepinephrine is estimated to be about twice as potent as epinephrine

in raising the systolic blood pressure. When administered subcutaneously to normal subjects 0.3 to 0.4 mgm. of norepinephrine produces the same rise in systolic blood pressure as 0.6 to 0.7 mgm. of epinephrine.

The drugs differ on their effects on the diastolic blood pressure. Norepinephrine produces a rise in diastolic blood pressure which parallels the systolic blood pressure while epinephrine frequently lowers the diastolic blood pressure. Thus, the pulse amplitude is markedly increased after injections of epinephrine while after norepinephrine there is no change or only a slight increase.

Heart Rate. Similar to neosynephrine, pressor doses of norepinephrine produce a slowing of the heart rate. Electrocardiograms taken during the infusions of the drug resemble those described for increased vagal activity. This bradycardia is blocked by previous administration of atropine. It is well known that injections of epinephrine in man may produce an increase in heart rate, although bradycardia has also been reported. Since norepinephrine increases the force and rate of contraction of the isolated heart, the bradycardia observed in normal volunteers is of reflex origin. Impulses resulting from stimulation of the pressoreceptors in the carotid sinus and aortic arch (by the increased blood pressure) are transmitted to the vaso-motor and cardio-inhibitory centers via the glossopharyngeal and aortic (depressor) nerves, and changes in the heart rate are mediated via the vagi.

Cardiac Output and Peripheral Resistance. In contrast to the increase in cardiac output measured during infusions of epinephrine, norepinephrine fails to produce an increase and usually produces a moderate decrease. Employing the direct Fick method of measuring cardiac output in normotensive individuals, Goldenberg and his co-workers found that with doses of both drugs which produced similar increases in systolic blood pressure the cardiac output was not significantly changed during infusions of norepinephrine while epinephrine produced an increase of from 78 to 98 per cent. A decrease in cardiac output following norepinephrine has been demonstrated by ballistocardiographic methods. During the infusions of norepinephrine the normotensive individuals showed a sharp increase in total peripheral resistance; in contrast, there was

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SUMMARY CHART

	NOREPINEPHRINE	EPINEPHRINE
Chemical Structure		
Occurrence	Adrenals; organs; nerve fibers (predominant)	Adrenals (predominant); organs; nerve fibers
Assay	Color reactions; fluorescence; paper chromatography; biological preparations	
Blood Pressure	Increase systolic Increase diastolic Slight increase in pulse pressure	Increase systolic Decrease diastolic Marked increase in pulse pressure
Heart Rate	Bradycardia	Tachycardia (usual response)
Cardiac Output	No change or decrease	Markedly increased
Peripheral Resistance	Overall increase	Overall decrease
cerebral circulation	Increased resistance Slight decrease in flow No change in cerebral oxygen consumption	No significant change in resistance Increased flow Increased cerebral oxygen consumption
limb blood flow	Decrease	Transient increase
hepatic blood flow	Slight decrease in flow Increased splanchnic vascular resistance	Rise in flow Decreased splanchnic vascular resistance
Renal Hemodynamics	Both depress renal plasma flow and increase total renal arteriolar resistance	
Bronchodilator activity (in vitro)	Relatively weak bronchodilator	Potent bronchodilator
Metabolism	No significant change in oxygen consumption Slight increase in blood glucose level Slight lowering of eosinophil count	Increase in total oxygen consumption Moderate increase in blood glucose level Marked lowering of eosinophil count

a marked drop in total peripheral resistance during infusions of epinephrine.

Cerebral Circulation. The effects of

norepinephrine and epinephrine on cerebral circulation have been studied in healthy subjects (King *et al.*, 1951). Norepinephrine produced a marked

increase in cerebrovascular resistance; epinephrine produced no significant change. With approximately equal increases in mean arterial blood pres-



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sure, epinephrine produced an increase in cerebral blood flow while norepinephrine produced a slight decrease. Cerebral oxygen consumption was increased during infusions of epinephrine, but was not significantly altered by norepinephrine. Norepinephrine, therefore, is a potent vasoconstrictor.

Peripheral Blood Flow. The effects of norepinephrine on limb flow have been measured by means of plethysmographs and compared with the effects of epinephrine. Norepinephrine generally decreases limb flow while epinephrine produces a transient increase followed by a return to control levels or a smaller secondary increase.

Hepatic Blood Flow. Hepatic blood flow and splanchnic vascular resistance have been studied by Bearn *et al.* (1951) during infusions of norepinephrine and epinephrine. With equipotent doses (on systolic blood pressure) of both drugs, norepinephrine produced a slight decrease in hepatic blood flow and an increase in splanchnic vascular resistance; epinephrine produced a rise in hepatic blood flow and a decrease in splanchnic vascular resistance.

Renal Hemodynamics. The effects of norepinephrine on renal hemodynamics in man are similar to those of epinephrine. Both substances depress the renal plasma flow and increase total renal arteriolar resistance. Both drugs have been found to depress the urinary excretion of sodium and potassium; since the glomerular filtration rate remains relatively constant with increased arterial pressure and vasoconstriction, it has been concluded that the change in electrolyte output must be due to increased tubular reabsorption.

In Vitro Bronchodilator Activity. The effects of norepinephrine and epinephrine have been studied on isolated tracheal rings of animals and man. The drugs were compared by their ability to reduce by 50 per cent the contractions of the bronchial muscle induced by acetylcholine and by histamine. In general, norepinephrine was markedly less effective (1/2 to 1/100, depending on species) than epinephrine in reducing contractions induced by histamine or acetylcholine.

Metabolism. During infusions of norepinephrine the total oxygen consumption of normal healthy subjects changed only slightly from resting levels (increase or decrease, mean 1.6 per cent decrease); epinephrine, in equipotent pressor doses, produced an

increase in oxygen consumption (10.6 per cent increase).

Both drugs produce an increase in glucose released from the liver; however, norepinephrine is much less effective in evoking this response. During infusions of the drugs, norepinephrine produces a smaller rise in capillary glucose concentration than epinephrine. Furthermore, epinephrine produces an increase in blood lactic acid while norepinephrine has little effect.

With approximately equal amounts of drug, norepinephrine is about 1/6 as effective as epinephrine in lowering the eosinophil count.

Clinical: Because of its potent pressor effect and its effectiveness in increasing the total vascular resistance, norepinephrine is currently being investigated for use in shock, particularly where the administration of fluids is contraindicated or unnecessary.

Norepinephrine offers no advantage over epinephrine for use in conjunction with local anesthetics. As with epinephrine, subcutaneous administration of large doses of norepinephrine may produce sloughing owing to local ischemia. Under similar conditions norepinephrine has about the same onset and duration of action as epinephrine.—HYMAN L. COHEN, M.D.

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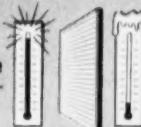
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Sanitation Should Be Built In

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IN PLANNING the over-all design and facilities of hospital kitchens, experts in the field of food preparation tend to emphasize factors which will achieve maximum production for the minimum capital outlay and minimum operating cost. With production in mind as a major goal, they sometimes fail to place proper emphasis on features conducive to good food sanitation. However, in recent years kitchen planners have come to appreciate more and more the close relationship between good sanitary construction and cost reduction.

FOOD MUST BE PROTECTED

The hospital kitchen is expected to be an asset in the care of the patient and must provide wholesome, pleasing food with maximum protection against food-borne disease. Adequate sanitary features are a major tool for this achievement and are neither more costly nor more difficult to obtain than inferior facilities are. Actually, good sanitation can reduce long-range costs. High quality sanitary equipment is durable, requires less effort to use and to maintain, and reduces replacement and labor costs. Thus the hospital kitchen management can work toward its objective of safe and pleasing food service without overstepping the limits of capital outlay plus operating expense. In those instances where capital outlay is greater, overhead can be accordingly reduced. The following items of sanitary construction are considered in the planning of a hospital kitchen:

A good floor, which is basic for all food preparation areas, should be de-

signed for durability and convenience of maintenance. Durability may be attained by use of terrazzo, ceramic tile, quarry tile, or other long wearing surfaces which will remain impervious to water and grease. Cleaning will be facilitated by the floors' being sloped toward strategically located drains. Rounded wall-floor unions prevent sharp corners which are difficult to clean.

Wall surfaces of choice are smooth, easily washable, nonabsorbent and durable. Areas subjected to splash deserve waterproof wall covering such as ceramic tile or concrete plaster. Wall openings for pipes should be snugly fitted or covered with tight-fitting metal collars to prevent easy rodent and insect access. Cockroach colonies sometimes establish themselves in frame or hollow tile walls.

Adequate lighting aids in making all operations more effective and encourages attention to cleanliness. Daylight is usually preferable, but must be supplemented with ample artificial light. Adequate distribution and capacity of fixtures, ease of cleaning fixtures, and light colors through the room will improve lighting. No dark areas, especially corners, exist in the efficient kitchen.

Proper ventilation not only exhausts odors, grease and excess moisture, but contributes greatly to employee comfort and efficiency. A properly designed hood and exhaust system eliminates grease accumulations on walls and equipment. Filters in the exhaust sys-

tem protect the exhaust piping from excessive grease which could otherwise be a definite fire hazard. Maintenance of filters is simplified if they are designed for cleaning in the dishwashing machine or sink.

Space allotted to food storage should be generous to prevent overcrowding of the storeroom and to permit proper food storage. Improper food storage results in rodent and insect infestations and does not allow the orderly turnover of stock. The racks and shelves should be constructed so that no food-stuff is stored directly upon the floor. This will minimize the opportunity for infestations by vermin and will also prevent water damage. Built-in bins are not recommended. Cans for such items as beans, rice, flour and salt should be mounted on rollers so that they can be easily moved during cleanup operations. Low platforms and shelves furnish an attractive harborage for rodents. Adequate storage space for housekeeping supplies is an important part of the over-all storage plan.

DESIGN FOR CLEANLINESS

The food preparation equipment should be designed so that it is easily cleaned and can be installed so that there are no inaccessible areas. Ranges are to be mounted far enough away from the walls so the floor behind them can be cleaned, or tight against the wall to eliminate spaces. There should be no areas beneath the equipment that cannot be properly cleaned. All equipment should be constructed of an easily cleaned material, a material that does not chip or become rough. All equipment should be free from unnecessary ledges or surfaces on which dust and dirt will collect. If shelves are used beneath tables or in the kitchen, they can

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be built in small sections so that they can be removed for cleaning; if small enough they can be put through the dishwashing machine. This is also true of refrigerator shelves.

Adequate refrigeration is the most important tool available to the food service worker in the prevention of food poisoning. The refrigerators must be capable of maintaining a temperature of 40° F. The capacity required will depend upon the number of people served, the diets served, the frequency of deliveries, and various other factors. There should be enough refrigeration space to prevent crowding. The shelves should be slatted and preferably of tubular construction to facilitate cleaning. However, the most important point in planning is to assure adequate space.

A great deal of thought is required in planning for dishwashing equipment and layout of the equipment. If a dishwashing machine is installed, an adequate supply of hot water must be available. The normal hot water system does not supply hot enough water for a dishwashing machine; therefore a booster heater for the rinse water will

be needed. The water consumption of each machine must be checked before the proper sized heater can be installed. To ensure satisfactory results dishes must be thoroughly prewashed before they are put through the machine. If possible, the prewashing equipment should be arranged so that it can be used for a complete hand dishwashing operation in an emergency.

Adequate sinks, preferably with three compartments, should be provided for pots and pans. The sinks should be large enough to wash the largest utensil used in the kitchen. For very large installations mechanical equipment for pots and pans may be advantageous.

Improper plumbing can be a serious hazard. Equipment involving water connections should be constructed so that there is no way for liquids to siphon back into the supply line. Most new equipment is satisfactory in this respect. However, certain pieces must be carefully selected to get a type which has no back-siphonage hazards. Dishwashing machines, potato peelers and coffee urns are examples of equipment that often have back-siphonage hazards. Make sure there are no exposed sewer pipes over food preparation, serving or storage areas. Sinks and other equipment that are placed next to the wall should be drained through a wall drain so that the floor is unobstructed for cleaning purposes. If possible, sinks should be hung from the wall so the floor is unobstructed. Dirt tends to accumulate around all obstructions. If legs are necessary, they should be round so that they are easily cleaned.

Toilet and lavatory facilities are an integral part of the kitchen. Lavatory facilities should be installed in strategic places throughout the food preparation area. Adequate dressing rooms and lockers for personal articles will aid in keeping the kitchen clean and uncluttered.

Facilities for garbage handling and garbage can washing should be planned into the kitchens. A garbage refrigerator is a great help in good garbage handling but is not necessary. The minimum facilities are an impervious platform for can storage and running hot water for scrubbing cans.

Sanitation advice is available in almost every section of the state through local health departments. Often an examination of plans by someone whose chief interest is sanitary food service will pay big dividends through the many years a kitchen will be in service.

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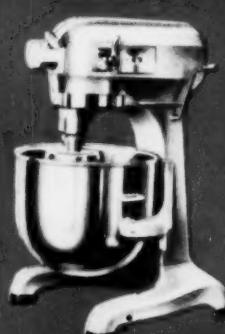
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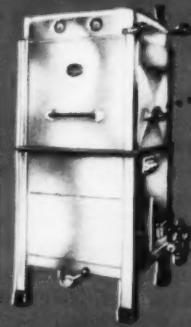


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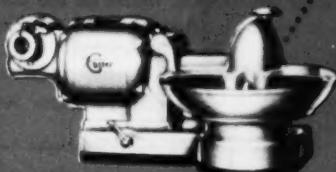


Inside story of a Kitchen Planned for Performance

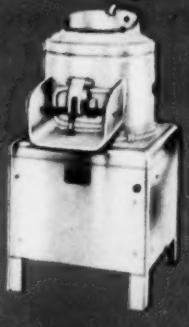
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Pitfalls to Avoid in Taking Inventory

Some methods of controlling food purchases, receiving and storage

A CAREFUL inspection of the storeroom frequently reveals the general operating efficiency of the food department. Some storerooms look like grandfather's attic — a storage place for never-again-to-be-used items. Often the inspection tells the tale of overbuying, or of a menu overloaded with slow-moving items. Efficient food operation requires purchasing that keeps stocks to a minimum; receiving and storing practices that make a clean, orderly showplace of the storeroom, and record-keeping that places as much importance on accounting for all food items as the accounting department places on the control of cash.

ACCURATE INVENTORIES

The first job is to ascertain that food inventories are accurate and complete. In many instances, after an otherwise careful job of accounting has been done, there is a suspicion that the real reason for a high cost of meals served in one month as compared with a low cost during the preceding month was an inaccurate inventory. If the food cost figures are to be reliable, they must have the sound foundation of accurate inventories.

We recommend the use of a bound book for taking storeroom inventories. This form of inventory record provides for the listing of items down the left-hand side of the page and 12 columns so that an item need be written only once each year with quantity set in and the price corrected, if necessary, at the end of each month. It greatly facilitates both inventory-taking and good storeroom control to arrange the food storeroom in such orderly fashion that the various food items on the list are always located in the same place. If the storeroom is arranged in this manner before the inventory book

HENRY T. MASCHAL

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San Francisco

is set up, it is possible to have the items listed in the inventory book in the same order as they appear on the storeroom shelves.

There is only one effective way in which to take a storeroom inventory, and that is to start at a suitable point in the storeroom and take item for item in order. This observation may appear elementary; nevertheless, in the course of our survey work in various types of institutions we have observed inventory-takers calling items as listed in the book and checking them to those found on the shelves, a procedure that overlooks entirely any new items that may have been added since the last inventory date.

One should be consistent with re-

gard to treatment of kitchen inventories. If they are usually taken monthly, this procedure should be followed regularly rather than occasionally accepting an estimated figure. Standard loose-leaf sheets are advocated for kitchen inventories because of the diversity of items found there.

One of the common errors we observe in inventory-taking is the failure to account for items that have been put in a separate storeroom because of inadequate space in the main storeroom. At times we find undue reliance placed upon perpetual inventories, with month-end inventories being taken from the perpetual inventory cards or sheets without verification by physical count of the items.

A question is often raised as to whether perpetual inventories of food stores are justifiable. From the control standpoint they are not, unless they are maintained by someone in the accounting office rather than in the storeroom. On the other hand, a perpetual inventory does facilitate purchasing, as it provides a record from which the purchasing agent can readily ascertain the source and price of the last purchase of a given item and the rate of consumption during any given period. If it is customary for the purchasing agent to buy a 30 day supply of canned goods at a time, he can readily ascertain the average 30 day consumption for the previous periods from perpetual inventory records.

ESSENTIALS FOR CONTROL

1. Keep accurate inventories.
2. Obtain market quotations.
3. Keep stocks at a minimum.
4. Establish and conform to purchase specifications.
5. Carefully inspect all items; determine accurate count or weight.
6. Promptly record receipt of all goods placed in stock.
7. Promptly store all items and keep them in good condition.
8. Maintain accurate records of all items.
9. See that proper requisitions are executed for all items issued.
10. Avoid unnecessary paper work.

SHOULD BE WRITTEN RECORD

The purchasing agent or whoever does the buying should be provided with a printed form for recording market quotations. In some institutions a complete, formal purchase order is prepared for all food items, including perishable fruits, vegetables and meats.



TOASTMASTER

Roll and Food Warmers Speed Hot Food from Kitchen to Patient!

You can serve foods faster and at lower cost with "Toastmaster" Roll & Food Warmers. In these mobile units, individual patient's plates can be kept hot and oven-fresh for hours! Food for all floors is prepared in one location and wheeled to the various floor diet kitchens.

Serving time is shortened because patients can be served directly from the "Toastmaster" Roll & Food Warmer. Trays for each patient are filled and served "on the spot." This saves lengthy trips to the main kitchen and frees valuable help for duty elsewhere.

Stationary units without casters are also available for use as permanent food stations. Efficiency can be increased by careful placement of these "booster" food warmers.

A wide variety of foods can be kept hot and appetizing in this thermostatically controlled equipment. Rolls are kept deliciously hot . . . meats stay tender and flavorful. Vegetables, casseroles—almost everything your hospital serves will hold its fresh-cooked goodness until served.

No shrinkage, drying-out or sogginess. The "Toastmaster" Roll & Food Warmer has an exclusive heat circulation and humidity control system. And sealed drawer construction prevents transfer of odors between drawers. A plug-in appliance—no steam or hot water connection—no installation expense.

Ask your Food Service Equipment Dealer to show you how this modern equipment can step-up food service and cut serving costs for your hospital. See him about it today.

TOASTMASTER

Roll and Food Warmers

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3- and 4-drawer
models can be equipped
with casters, rubber bumpers,
and handle-bar for mobile use.



4-DRAWER MODEL (as shown)

\$515.00†

†Price slightly higher in
the Pacific Coast states.

Available in Sizes to Suit Every Hospital Need

4-DRAWER MODEL 4DL
(not shown) 27" square, 44" high

3-DRAWER MODEL 3DS
(not shown) 23" square, 44" high

3-DRAWER MODEL 3DL
(not shown) 27" square, 44" high

2-DRAWER MODEL 2DS
(not shown) 23" square, 22 1/4" high

This is an unduly cumbersome approach to the daily purchase of perishable commodities, and it is our opinion that a form of market quotation sheet is preferable, on which the purchasing agent can record the price quoted by the various vendors he has contacted and on which he can indicate the quantity and price he has committed for. There are various types of market quotation sheets that can readily be obtained from stationers.

CHECK WHEN RECEIVED

It is the receiving clerk's respon-

sibility to record the quantity and grade of foodstuffs received. It has long been established as an axiom that all items received should be carefully checked and weighed. Yet we frequently find that the scales at the receiving entrance are not regularly used and that the receiving clerk is doing a perfunctory job of checking in the purchases.

What can the hospital hope to accomplish by engaging a competent purchasing agent if the receiving clerk is not sufficiently dependable to make certain that the institution gets pre-

cisely the quantity and quality it has been billed for? If the receiving clerk is not deemed competent to pass upon the grade and quality of foodstuffs, such items should be checked daily either by the purchasing agent or by the head of the food service department.

The standard receiving sheet used in many operations serves a twofold purpose: One is to maintain a complete record of food items coming into the storeroom; the second is to facilitate a daily total of purchases going directly to the kitchen, the first step in a simplified running daily food cost accounting system. The receiving record with distribution columns on the right-hand side of the sheet permits obtaining the totals of the foods that have been sent directly to the kitchen as well as any supplies or sundries that have been transferred to other storerooms.

It is necessary to match up all quotations from vendors with the actual amounts charged on their invoices. This "matching up" should be done in the accounting office and all differences promptly run down and adjusted. If credit memorandums are to be obtained from the suppliers, it is well to follow up such items at once rather than to deal with the problem of adjustments at the month's end.

REQUISITIONS

Proper storeroom control requires the installation and operation of an effective requisition system. Requisitions should be numbered and in duplicate. The second copy should be retained by the chief dietitian, chef or other department head receiving the merchandise. This procedure facilitates complete future check of requisitions whenever necessary. Requisitions should be prepared and signed by the department head. In many instances, however, we find requisitions are prepared by the storeroom clerk and subsequently submitted to the department head for the formality of signature.

In large operations provision must be made for an accurate record of transfers between kitchens. The final figures relative to the cost per meal served or the cost in relation to sales volume is of little comparative value with regard to a particular type of meal served or the service from a particular kitchen if the transfers between kitchens have not been carefully recorded.

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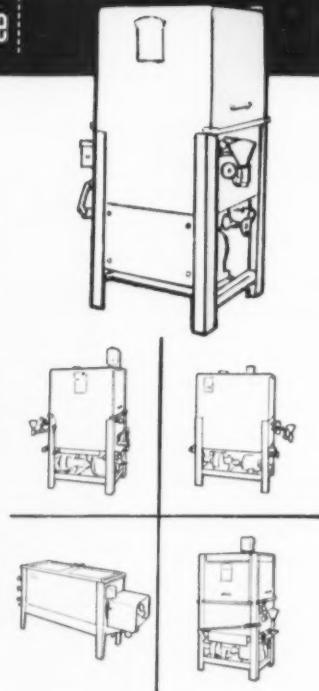
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For Time Control of Dishwashing Cycle — An improved hydraulic operated timed wash and rinse control unit for the complete wash, dwell and rinse cycle. The simplest and most dependable timer made.

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"...more economical and practical, all around..."



ERIE COUNTY HOSPITAL KITCHEN

says Hospital Manager about Boontonware

"We switched to Boontonware for patient use about four years ago. Since then, we have re-ordered for the staff and will soon be using nothing but Boontonware.

"One cup handle has been our entire loss in all this time. So you can appreciate what we have saved in former replacement costs.

"Patients delight in two features particularly — the cheery note of its color and the way that its insulat-

ing quality preserves the appetizing serving temperature of foods. And tray-carrying nurses are so grateful for its light weight.

"We think Boontonware is more economical and practical for hospital operation, all around."

ERIE COUNTY, PA.
TUBERCULOSIS HOSPITAL

Edward J. Dot
Business Manager

Wherever style and durability in dinnerware are important, Boontonware is working the same wonders. Find out more about it. See it, handle it — yes, drop it, if you want proof-positive.

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for the name of your nearest Dealer.

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fine dinnerware fashioned of MELMAC®

Boontonware complies with CS 173-50, the heavy-duty melamine dinnerware specification as developed by the trade and issued by U. S. Department of Commerce, and conforms with the simplified practice recommendations of the American Hospital Association.



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FOOD FOR THOUGHT

Data on Defrosting

When, how and even why to defrost differs considerably with the two appliances, refrigerators and freezers, according to Dr. Earl McCracken, Bureau of Human Nutrition and Home Economics, U.S. Department of Agriculture.

Frost on the evaporator of the refrigerator should never become more than $\frac{1}{4}$ inch thick. The thicker the frost, the more it insulates or "blankets" the evaporator and reduces its cooling effect on the interior of the refrigerator, no matter how much the motor runs. Thus, thick frost lets the

inside of the refrigerator warm up so that foods don't keep so well. Most refrigerators need defrosting at least once a week—or oftener in summer when hot weather plus more use of the refrigerator for chilled foods and beverages causes frost to form faster. Follow the directions in the booklet that comes with the refrigerator as to how to defrost, advises Dr. McCracken. Some manufacturers advise quick defrosting with hot water in the ice trays while others warn against it. Some refrigerators have automatic defrosting.

In contrast to the refrigerator, freezers or freezer compartments of refrigerators should need defrosting only once or twice a year. Best management calls for removing frost when it is about $\frac{1}{2}$ inch thick on large areas of walls or shelves. However, Dr. McCracken's tests show that frost can accumulate up to $1\frac{1}{2}$ inches thick (in the chest type of freezers operating at 0° F.) without warming the interior of the freezer enough to endanger frozen food. Even this excessive frost did not cause much more than normal running of the freezer motor, Dr. McCracken reports. Thick frost in a freezer is wasteful because it cuts down storage space, and because as much electricity is spent holding frost at zero as on frozen food that should be occupying the space.

Frost can be removed while the freezer is in operation by scraping. Scoop tools are made especially for this job. These catch the frost as they scrape it off. Some of the new types are made of plastic. Never scrape with anything sharp enough to damage freezer walls or the gasket around the opening.

Ice that forms in the freezer is too hard to scrape off so must be melted. To remove ice, disconnect the freezer and take out the food. Then melt ice off by running cold water over it, if the freezer has a drain. Otherwise, hasten the melting by placing an electric fan so that it blows cold air out and warm air in. Remove ice as it loosens, and keep sponging up the water that forms. Have the inside dry when you connect the electricity and put back the frozen food.

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Phonacall is designed especially for hospital service—and each system is individually planned to best serve the hospital where it is installed. Write for further information.



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Menus for September 1953

1 Grapefruit Juice Scrambled Eggs, Toast Broiled Ham With Sliced Pineapple Mashed Sweet Potatoes Coleslaw-Tomato Wedges Delicia Cake Swedish Meat Balls Mushroom Sauce Corn-on-the-Cob Apricots	2 Orange Juice Bacon, Toast Broiled Steak Stuffed Baked Potato Tossed Vegetable Salad Cherry Upside-Down Cake Tongue and Cheese Sandwiches Buttered Wax Beans Celery and Pickle Sticks Sliced Fresh Peaches Icebox Cookies	3 Cantaloupe Soft Boiled Egg, Toast Roast Pork Loin Glacé Carrots Buttered Broccoli Wilted Lettuce Fresh Apple Pie Creamed Chipped Beef Mashed Potatoes Sliced Tomato Salad Hot Biscuits Chocolate Blancmange, Whipped Cream	4 Grapefruit Segments Eggs to Order, Toast Salmon Salad French Fried Potatoes Buttered Asparagus Vienna Rolls, Jam Orange Ice Sponge Cake Omelet, Spanish Sauce Buttered Green Beans Banana Nut Salad Icebox Dessert	5 Stewed Prunes Bacon, Toast Roast Beef With Gravy Mashed Potatoes Buttered Spinach Tomato and Cucumber Salad Pineapple Tapioca Hamburger on Bun Potato Chips Tossed Green Salad Watermelon	6 Orange Half Assorted Sweet Rolls Fried Chicken With Cream Gravy Parsley Buttered Potato Buttered Green Peas Pimiento Coleslaw Fresh Sliced Peaches on Angel Food Cold Cuts Buttered Kidney Beans Fresh Fruit Salad Chocolate Ice Cream
7 Tomato Juice Poached Egg on Toast Baked Pork Chops Baked Sweet Potatoes Creamed Cauliflower Apple Crisp Roast Beef Sandwich Buttered Rice Sliced Tomato Salad Fruit Punch Date Bars	8 Blended Fruit Juice Eggs to Order, Toast Broiled Liver, Mushroom Sauce Rissoli Potatoes Buttered Summer Squash Wilted Lettuce Honey Dew Melon Bacon Curls Carrot Cutlets Currant Jelly Stuffed Celery Plain Muffins Stewed Fresh Peaches	9 Grapefruit Segments Omelet, Toast Baked Canadian Bacon Corn-on-the-Cob Yankee Cole Slaw Hot Rolls Applesauce Meat Loaf, Spanish Sauce Potato Puffs Buttered Spinach Fresh Fruit Salad Icebox Cookies	10 Pineapple Juice Sausage Links, Toast Chicken Salad Waffle Potatoes Creamed Wax Beans Parker House Rolls Melon Cup Cube Steak Creole Noodles Chef's Salad Burnt Sugar Cake	11 Tomato Juice Eggs to Order, Toast Fried White Fish, Tartare Sauce Escaloped Potatoes Buttered New Beets Dill Cole Slaw Lemon Pie Shrimp and Egg Salad Rice with Tomatoes Buttered Green Peas Orange Ice Sugar Cookies	12 Cantaloupe Bacon, Toast Broiled Lamb Chops Parsley Buttered Potato Fresh Spinach Salad Bread Pudding, Fruit Sauce Mock Drum Sticks With Thin Gray Mashed Potatoes Stuffed Tomato Salad Sliced Fresh Peaches
13 Sliced Bananas Assorted Sweet Rolls Roast Pork Loin Buttered New Corn Pimento Cauliflower Vienna Rolls Apple-Orange-Grape Salad Chocolate Sundae Cold Cuts Potato Salad Celery and Ripe Olives Sponge Cake	14 Apricot Nectar Soft Cooked Egg, Toast Braised Short Ribs of Beef Franconia Potatoes Minted Carrots Lettuce With Caper Dressing Orange Floating Island Bacon and Tomato Sandwich Potato Chips Iced Cocoa Icebox Cookies	15 Grapefruit Segments Muffins, Jam Chicken à la King Anna Potatoes Buttered Asparagus Tossed Salad Watermelon Baked Smoked Tongue, Raisin Sauce Baked Acorn Squash Harvard Beets Fresh Peach Cobbler	16 Sliced Orange Scrambled Eggs, Toast Baked Ham Buttered Green Lima Beans Broiled Tomatoes Pineapple Salad Ice Cream Hamburger Balls, Mushroom Sauce Corn-on-the-Cob Mixed Green Salad Icebox Dessert	17 Stewed Prunes Sausage Cakes, Toast Minute Steak Riced Browned Potatoes Coleslaw With Tomato Hot Biscuits Bing Cherries Creamed Sweet Breads on Rusk Potato Chips Fresh Fruit Salad Chocolate Layer Cake	18 Stewed Prunes Bran Muffins, Jam Baked Halibut With Lemon Slices Creamed Potatoes and New Peas Fresh Pear Salad Butterscotch Pudding Salmon Croquettes Cheese Sauce Buttered Rice Asparagus Salad Limeade Ginger Cookies
19 Cantaloupe Poached Egg on Toast Roast Beef With Brown Gravy Mashed Potatoes Stewed Fresh Tomatoes Lettuce With 1000 Island Dressing Honey Dew Melon Frankfurters in Coney Islands Potato Salad Celery Hearts Fruit Bowl	20 Applesauce Coffee Cake, Bacon Veal Cutlets With Pan Gravy Potato Cubes With Chive Butter Buttered Green Beans Apricot Salad Whole Wheat Rolls Ice Cream Bars Tuna Salad Finger Sandwiches Potato Chips Carrot and Turnip Sticks Royal Anne Cherries Angel Food Cake	21 Grapefruit Segments Creamed Beef on Toast Roast Spare Ribs, Spanish Sauce Oven-Browned Potatoes Buttered Broccoli Wilted Lettuce Vanilla Pudding Baked Stuffed Peppers Mashed Potato Patties Beet and Egg Salad Bavarian Cream	22 Fresh Pears Scrambled Eggs, Toast Stewed Chicken With Dumplings Chef's Salad Boston Cream Pie Breaded Liver Hashed Browned Potatoes Creamed New Onions Sliced Tomato Salad Melon Cup	23 Honey Dew Melon French Toast Baked Pork Chops With Dressing Buttered Green Lima Beans Red and White Cabbage Slaw Apple Tapioca With Whipped Cream Salisbury Steak Creamed Fresh Corn Broiled Tomatoes Bran Muffins, Jam Pineapple Crisps	24 Orange Juice Soft Cooked Egg, Toast Pot Roast Beef With Vegetable Gravy Oven-Browned Potatoes Buttered Green Beans Lettuce With French Dressing Watermelon Grilled Cheese and Ham Sandwich Escaloped Cauliflower Relishes Fresh Peach Pie
25 Grapefruit Juice Eggs to Order, Toast Tuna and Noodle Casserole Glace Carrots Spinach Salad Vienna Rolls Raspberry Ice Omelet With Sardines Pittsburgh Potatoes Tomato Salad Baked Fresh Pears Cup Cakes	26 Orange Half Bacon, Toast Pork Patties Buttered Green Beans Creamed New Peas Cinnamon Apple Rings Chocolate Pudding Chopped Hash Buttered New Beets Chef's Salad Hot Biscuits Fresh Fruit Bowl	27 Pineapple Juice Coffee Cake Fruit Cup Fried Chicken With Cream Gravy Parsley Buttered Potato Relishes Date Torte With Whipped Cream Chicken Salad Sandwich Potato Chips Buttered New Peas Sliced Tomatoes Honey Dew Melon	28 Tomato Juice Scrambled Eggs, Toast Ham Loaf Stuffed Baked Potato Stewed Tomato With Okra Carrot Salad Floating Island With Orange Slices Broiled Lamb Chops Succotash Waldorf Salad Chocolate Sundae	29 Kadota Figs Eggs to Order, Toast Swiss Steak Whipped Potatoes Tomato and Lettuce Salad Melon Cup Cup Cakes Spaghetti With Meat Balls Buttered Peas Coleslaw Sliced Fresh Peaches Coconut Macaroons	30 Honey Dew Melon Bacon, Toast Boiled Corned Beef Baked Bananas Kidney Bean Salad Raspberry Shortcake With Whipped Cream Chop Suey Chinese Noodles Pineapple and Apricot Salad Bread Sticks Date Bars
Ready-to-eat or cooked cereals served on all breakfast menus.					

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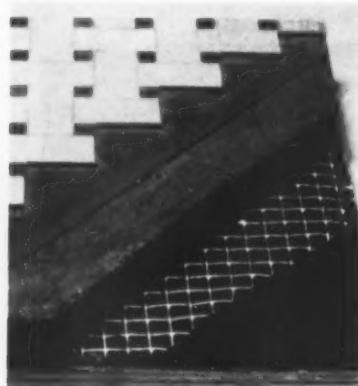
Offer expires August 1, 1954

Maintenance and Operation

Safety in Surgery Starts on the Floor

SAFETY in the surgeries and delivery rooms of the enlarged Hospital of the Good Samaritan, Los Angeles, has been greatly enhanced by the introduction of a new conductive unglazed ceramic floor, used here for the first time anywhere.

Tests of the first installation made by the Fire Prevention Bureau of Los Angeles and the state of California fire marshal's office show that conductivity is well within the limits recommended by the National Fire Protective Association and the National Bureau of Fire Underwriters.



The idea for the new floor was originated by Samuel E. Lunden, F.A.I.A., of the firm of Lunden, Hayward & O'Connor, architect of the hospital, and utilizes an ingenious arrangement of vitreous ceramic conductive dots to provide a positive electrical path from the surface of the tile floor to the underbed on which the tile is supported.

Everything in the room—equipment, tables, wheeled devices, and, of course, the shoes of the operating room personnel—has a conductive contact to the floor. This floor electrically connects persons and objects to prevent the accumulation of electrostatic charges. Accidental discharge of static electricity has been reported to be the cause of accidents.

The impervious, green granite, oblong tiles forming the background of

the floor pattern blends with the green glazed wall tile. Additional safety against the shock hazard is provided because this impervious floor tile is not affected by moisture as many porous flooring materials are.

Since the floor is the most practical and convenient conductor between persons and equipment in a room in which electrostatic charges may be developed, flooring materials have been the subject of research toward solutions of the problem of preventing such charges in operating rooms. The materials used must have surfaces which allow for thorough cleaning, but other factors which also enter into the selection of a floor covering or topping include resistance to wear of the material itself, and the life of the conductivity built into the floor covering.

Conductive ceramic floor tile is installed on the same principles as regular ceramic floor tile, except that acetylene carbon black is added to the setting materials. Installation in existing buildings has been simplified by the use of conductive adhesive for a setting bed. The total thickness of the tile and the setting material is $3/8$ inch. Installations in new buildings

Left: Cross section of various layers of floor. Below, left: A fire inspector demonstrates the fitting of conductive slippers. Right: Workmen cleaning the unglazed ceramic tile floor.

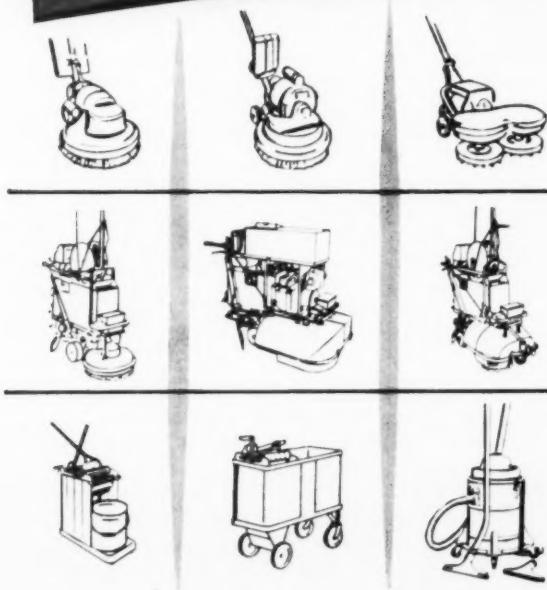


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men happy . . .**



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Choose from the **COMPLETE Finnell Line**
More than a score of models and sizes
permits selection of the equipment
that's exactly right for your job!



However much a maintenance man may want to do a good job, and at the same time show savings in labor costs, he's stymied if the machine is too small, or too large, or is otherwise unsuited to the job. Different floors and areas call for different care and equipment. That's why *Finnell makes more than a score of floor-maintenance machines*. From this complete line, it is possible to choose equipment that is correct in size as well as model . . . that provides the maximum brush coverage consistent with the area and arrangement of the floors.

Finnell makes Conventional Polishing-Scrubbing Machines in both concentrated and divided-weight types, each in a full range of sizes . . . a Dry-Scrubber, with self-sharpening brushes, for cleaning grease-caked floors . . . Combination Scrubber-Vac Machines for small, vast, and intermediate operations, including gasoline as well as electric models . . . Mop Trucks . . . Vacuum Cleaners for wet and dry pick-up, including a model with By-Pass Motor. In addition, *Finnell makes a full line of fast-acting Cleaners* for machine-scrubbing . . . Sealers and II axes of every requisite type . . . Steel-Wool Pads, and other accessories — everything for floor care!

In keeping with the *Finnell* policy of rendering an individualized service, *Finnell* maintains a nation-wide staff of floor specialists and engineers. There's a *Finnell* man near you to help solve your particular floor-maintenance problems . . . to train your operators in the proper use of *Finnell Job-Fitted Equipment and Supplies* . . . and to make periodic check-ups. For consultation, demonstration, or literature, phone or write nearest *Finnell Branch* or *Finnell System, Inc.*, 1408 East St., Elkhart, Ind. Branch Offices in all principal cities of the United States and Canada.

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are made by using adhesives or a Portland cement and sand setting bed.

One of the outstanding advantages in this new system is that it allows for a maximum control of conductivity. The entire surface contact is with the conductive dots which have a controlled resistance. Actually, these conductive dots could be placed in the class of an electric resistor made of porcelain.

The most popular background color of the ceramic floor is porcelain green stipple, having the same qualities as the restful, satin-glazed green wall

tile. However, the background can be selected from a palette of more than 20 colors. Unglazed ceramic floor tile is known to be easy to walk on. Even when the ceramic tile surgery floor is wet, it will not become slippery. This property results from the surface texture of the floor. The conductive ceramic tiles are 1/4 inch thick, which allows each piece to be well bonded to the cement floor. The joints are finished flush with the square edges of the tile, and the grout is a permanent waterproof gray or colored Portland cement. The nonabsorptive quality of

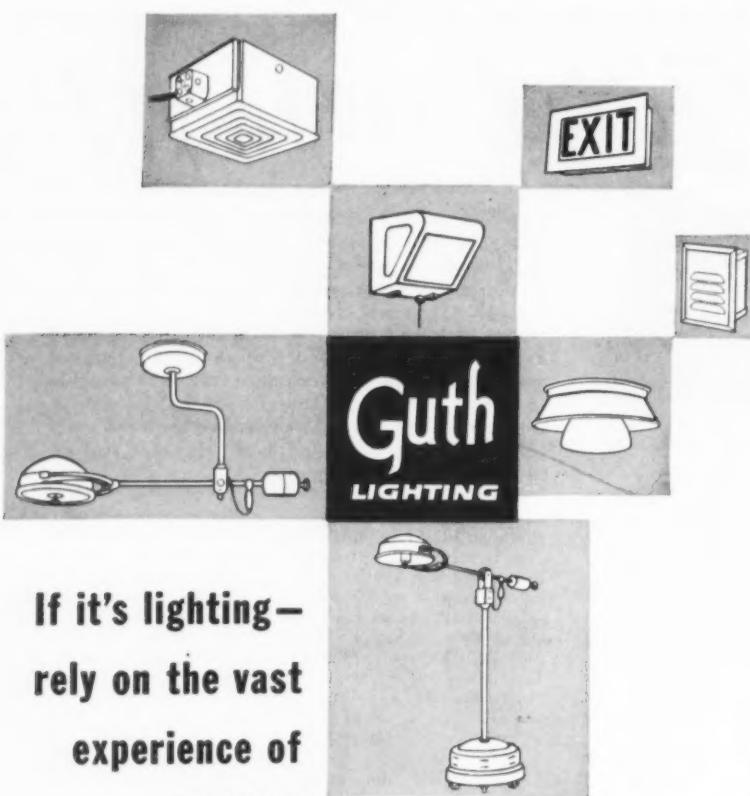
the vitreous tile floor preserves the beauty and is the contributing factor to ease of maintenance; special seal or wax treatments are not required. Tile will withstand the new detergents and has been known to withstand acids, alkalis and all types of soaps for years.

Mr. Lunden's system of conductive ceramic tile floor has all the qualities of a hospital surgery floor as listed by the U. S. Public Health Service, Division of Hospitals, in its report, "Low Cost Conductive Floors for Hospitals." It provides maximum safety as the vitreous tile will resist moisture, pressure and wear, thereby providing the desirable range of conductivity at all times.

Two of the many advantages of this flooring are its fireproof (not fire resistant) and waterproof qualities. The impervious square edge (not cushion edge), oblong tiles are easy to clean as they resist stains. The fact that they do not absorb water makes a more stable, conductive floor. Tile or other materials that are classed as conductive and used on the entire floor surface should absorb less than 0.5 per cent by weight in order to minimize the shock hazard.

Dark colors of conductive tile and other flooring materials absorb light and detract from the appearance of the operating room. The latest recommendation of the N.F.P.A. is for a floor surface that has no nonconductive element more than 1/4 inch from the conductive element. Patterns of black and green tile that are now obtainable meet this requirement. One of the new patterns combines green granite oblongs with the conductive black square safety tile. Many authorities approve the Lunden system of conductive ceramic tile flooring for hospital surgery units provided satisfactory contact is made between equipment and the floor. This method offers protection and allows the use of any color of tile for the background of the floor pattern.

Cost of installation varies in different areas, depending upon labor costs, shipping distances and other factors, but an approximate average for the installation of conductive ceramic tile in conductive adhesive is \$1.60 to \$1.75 per square foot, possibly less. The same material set in mortar made conductive with the addition of carbon black would run from \$1.85 to \$2 per square foot. Conductive floors require the same cleaning and maintenance as do ordinary tile floors.



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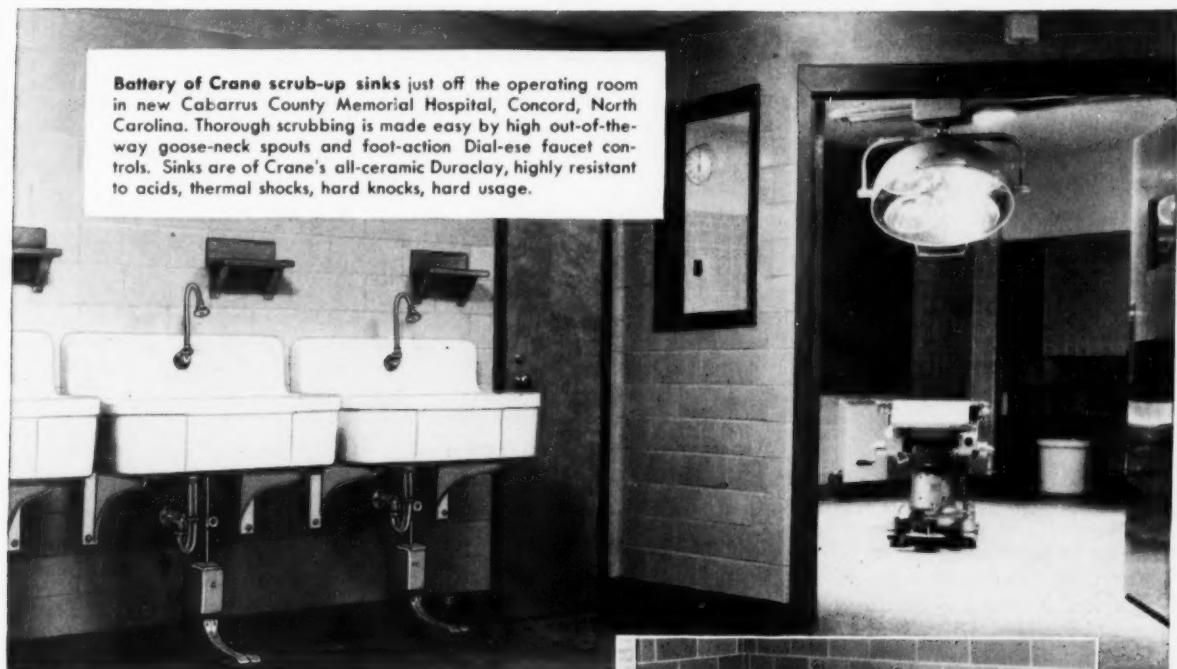
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New Hospital Chooses Newest Equipment —Crane Specialized Fixtures with Dial-ese Controls



Battery of Crane scrub-up sinks just off the operating room in new Cabarrus County Memorial Hospital, Concord, North Carolina. Thorough scrubbing is made easy by high out-of-the-way gooseneck spouts and foot-action Dial-ese faucet controls. Sinks are of Crane's all-ceramic Duraclay, highly resistant to acids, thermal shocks, hard knocks, hard usage.



Wrist-action Dial-ese controls save time and lost motion for operator when using this Crane Double Utility Tray. Water flows at a touch and shuts off securely.



New Cabarrus County Memorial Hospital, Concord, North Carolina. Architect, J. N. Pease & Co., Inc. General Contractor, J. A. Jones Construction Co. Plumbing Contractor, A. Z. Price & Associates, Inc. All of Charlotte, North Carolina.

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Syringe Washer Saves Nursing Hours

NELSON O. LINDLEY

Assistant Director
Beth Israel Hospital
Boston

FOR some years our central supply room at Beth Israel Hospital, Boston, had been faced with the ever mounting problem of washing syringes for the hospital. When we were approached by a local company to test out a newly designed glassware washer, we readily agreed, with the thought in mind that such a labor-saving device, if properly designed, would be of great assistance and would save many man-hours of work. The task of "banding," soaking, rinsing and brushing 18,000 syringes every month was using up many valuable hours of labor.

The washer consists of a wheel to which four baskets can be attached. The baskets, filled with syringes or other glassware, are then rotated through a heated detergent solution. The basic principle of "filling and draining" the glassware as it passes slowly through the solution has proved highly successful in our experiments, which lasted over a period of three months.

Designed of 16 gauge stainless metal and measuring 29 inches high by 27 inches wide and 23 inches deep, the washer resists acids and tarnish and is extremely rugged and simple in construction. We appreciated particularly the effort made to steer clear of gadgets, complicated moving parts,

and controls, in order to minimize our repair and maintenance problems. The machine requires a hot water inlet, a drain, and 220 volt, 4500 watt, 60 cycle, single phase electrical connections. Two built-in heating units are used to ensure proper solution temperature during the wash cycle. The "open side" stainless baskets are designed to hold the following number of syringes in anodized aluminum holders:

2 cc. syringes—64 per basket
5 cc. syringes—42 per basket
10 cc. syringes—30 per basket

We found that 75 per cent of our syringes fall within the aforementioned groups, and the ease of washing them in these special holders which are placed inside the baskets has been of great assistance. A normal wash load of four baskets of syringes requires a 30 minute cycle to complete one wash and two rinses. When the syringes have been thoroughly washed, the complete syringe holder is removed from the baskets ready for the next step, which may be performed later,

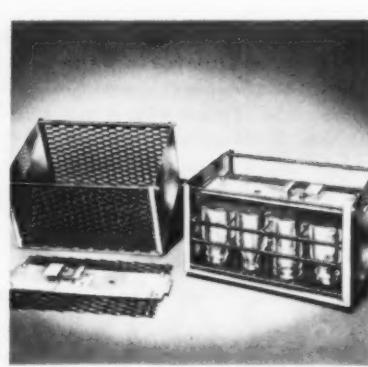
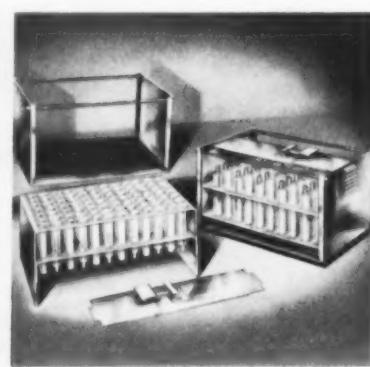
of matching barrels and plungers before being packed and autoclaved. The basket meanwhile may be used for another wash load.

For syringes larger than 10 cc., there is a slightly different basket which not only will accommodate syringes but has worked very well for us with petri dishes, medicine glasses, needle holders and even formula bottles.

The experiments we have conducted over a period of three months in our central supply room have resulted in a few minor changes in design, such as a "quick acting" valve for draining the washer in order to save time, a new splash protector for the operator, and a slight modification in size of the machine. However, the basic design was satisfactory from the day we started.

Some employes who were a little slow to change their methods now find they can't perform the syringe washing properly without the machine. Helen Jeffrey, R.N., our central supply room supervisor, states that there has been considerably less breakage and that the washer saves four hours of labor per day, an important factor indeed in personnel economy.

Left to right: Front view of machine mounted on portable cart showing syringe basket in place; syringe basket with syringe holder removed (left) and in position (right); basket used for large articles of glassware.





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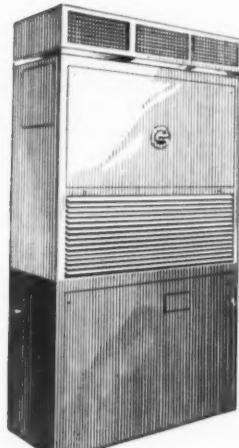
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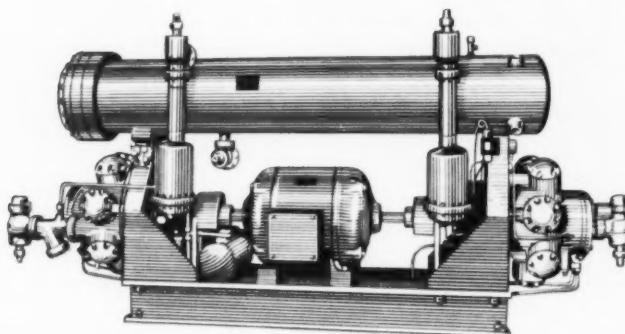


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The V. A. Sets Up Housekeeping



TRAINING MANUAL ON MOPPING — 5

IN this issue The MODERN HOSPITAL presents the concluding section of the Training Manual on Mopping prepared by the Veterans Administration for use in its hospitals. Other manuals in this series cover sweeping (which was presented in the January, February and March issues), dusting and waxing. The first section of the Training Manual on Dusting will appear in the September issue of this magazine.—ED.

132. The commonly used expression "damp sweep" is something of a misnomer. While it is a sweeping operation it also serves to hold down the dust and to remove spots which broom sweeping will not dislodge.
133. It is a job which, in essence, is a mopping rather than a sweeping procedure, yet its commonly used title would indicate that it is a "sweeping operation." Inasmuch as it will be performed by the mapper, it is included in this manual.
134. Here Moppy shows an expedient method of damp sweeping. He comments that if he does not have a wet mop available he can use as a substitute tool a broom with a clean damp cloth covering the sweeping section of the broom. He might even use a new damp dusting tool which has not been shown here. It is made up of a special mop stick which has clamps at the side to which a damp clean cloth can be attached. The damp cleaning cloth can be moved forward and thus provides several clean surfaces upon a single cloth.
135. Moppy has a very strong point here. He wants it distinctly understood that the damp sweeping procedure is to be used only upon floors that are essentially clean. It must never be construed that the damp sweeping procedure is a floor cleaning procedure. It is merely a sweeping procedure with emphasis upon holding down the dust.
136. What Moppy wants to drive home in this diagram is thus:
1. If hot water is used on his damp mop, or his cloth covered broom, it will serve to discolor the floor wax. Hot water will also more quickly reemulsify the wax and cause it to flush off onto the wet mop, thus reducing the wax coating upon the floors.
If a hot water mopping is combined with a reasonable amount of pressure upon the mop it will mar the wax coating considerably.
137. In summarizing his comments upon the damp sweep, Moppy repeats these points:
1. That it is a "dust-down" type of sweeping, and—
2. That this method is used only on floors that are essentially clean, and—
3. That it is faster than wet mopping and that many, many more square feet of area can be done in a given time than can be done with the complete mopping procedure.

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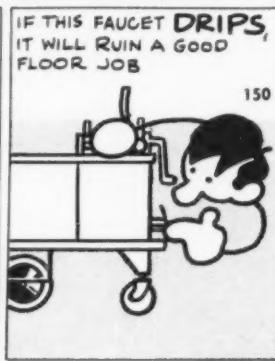
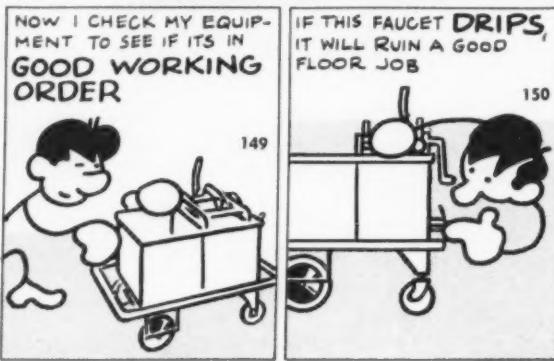
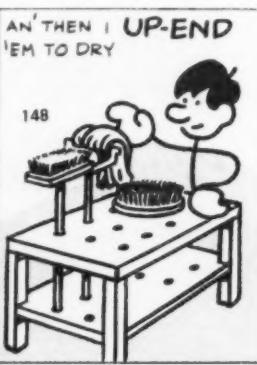
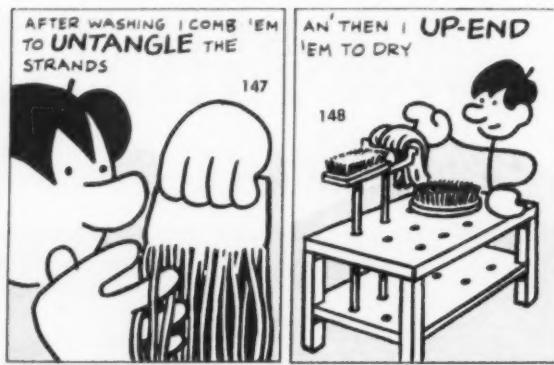
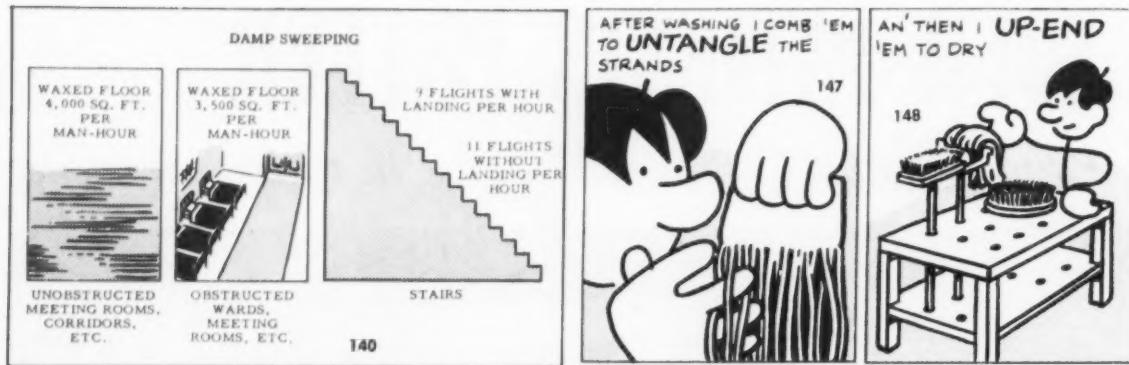
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140. 1. The first diagram showing open, unobstructed spaces where a worker will not be hindered or slowed down by obstructions denotes that this worker can damp sweep an area of approximately 400 square feet per man-hour.

2. The second diagram illustrating such obstructed areas as wards, meeting rooms, or other cluttered areas points out that a worker will do only approximately 3500 square feet of damp sweeping per man-hour.

3. Again using a 16 step stairway as a flight (or a unit) of measurement, we learn that a worker can damp-sweep either 9 flights plus landings or 11 flights with no landings per man-hour.

141. Moppy's day's work is done; he prepares to call it a day and go home.

142. Moppy realizes that he cannot perform a good cleaning job with dirty equipment. Neither can he have a feeling of pride in his equipment unless it is in good condition. So he starts to clean each piece of equipment before he puts it away for tomorrow.

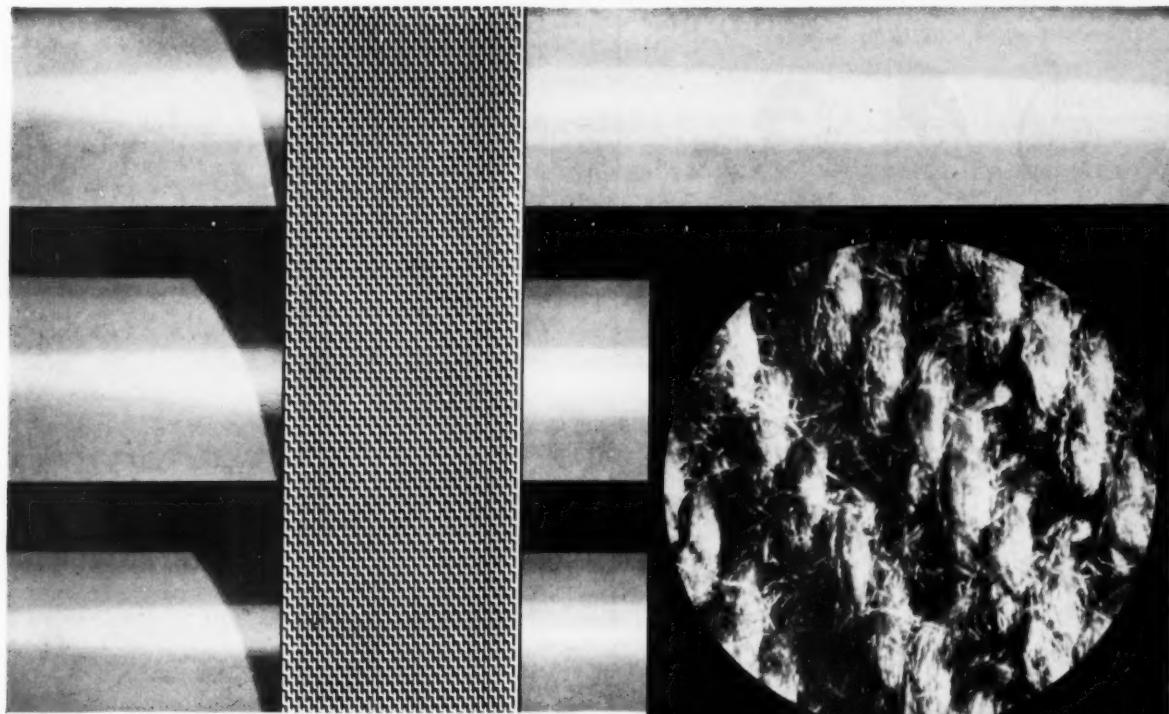
Another reason for cleaning the equipment so well is that he likes to start the next day right. Starting a new day's work with dirty equipment spoils his whole day for him and makes him grumpy.

143. It is an everyday occurrence for strands to break off cotton wet mops. They wind around the wringer rollers and around the casters and into the springs of the rollers or squeegee equipment. Unless they are removed the machinery cannot operate.

144. Moppy again emphasizes the need for at least a daily cleaning of mops. If he is doing especially dirty work he does not wait until the end of the day to wash out his mop; he washes it as frequently as conditions demand.

145. Moppy knows what the treatment of his mop will be when it is tumbler-dried at the laundry if he does not first tie the strands in place. So he smooths out the strands of his mop head and ties the strands in two places, near the head of the mop—and again about two-thirds of the way down from the head.

146. The mop washing will be Moppy's job oftener than it will be the laundry's. This does not daunt him, for his chief concern is always to have a clean mop with which to work. So he carefully and thoroughly washes out and rinses clean his mop (or mops).



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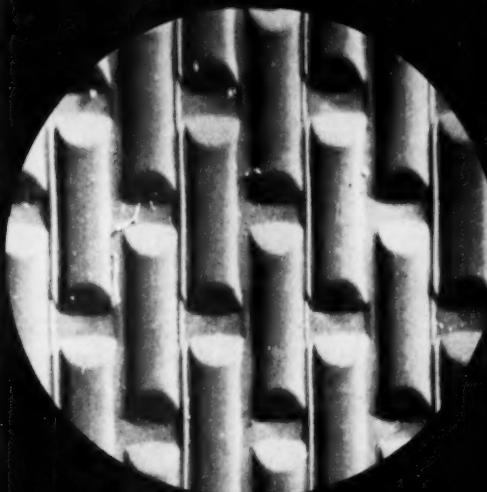
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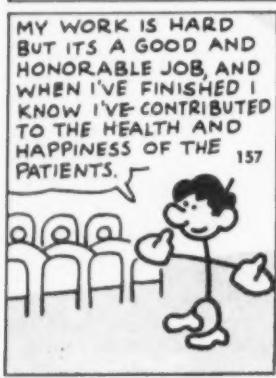
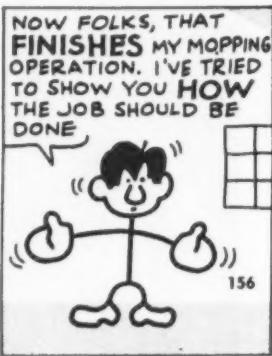
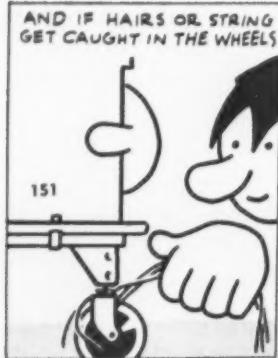
Surface of cotton tape,
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Surface of Flexalum plastic tape,
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*Gat-Baker Laboratory, New York City



147. Unless the mop strands are reasonably well straightened out they make the mop very awkward to work with. Moppy therefore uses his fingers as a comb, running them through the strands of the wet clean mop until they are all lying smoothly in the right direction.

148. Note here that Moppy has upended each piece of mop equipment that might be harmed by being left standing with the mophead down.

1. He has upended the wet mop so that it can air and so that it will dry out more easily and will not mildew.

2. He has upended the machine scrubbing brush. This he has carefully washed out, too, before putting it away. If he were so careless as to rest this expensive brush on its bristles he would ruin it. The bristles would be bent over and would do a less effective cleaning job.

3. His deck brush has been thoroughly washed out so that it will not develop odors. This too he upends so as to keep the bristles nice and straight.

149. If Moppy is working in a large hospital where he can use large equipment, he takes just as good care of the large equipment as he does of small items. He washes (or scrubs) his machine both on the inside and on the outside. He doesn't like to work with a machine that is all spattered.

150. Taps or faucets take a hard beating on mop trucks. Large amounts of silt and caustics and other harmful materials must pass through this outlet. The washers wear out quickly and before too long they will not close tightly. Moppy has had a few bad experiences with leaky taps on old mop trucks, so now he checks them frequently to see that they are not clogged with silt or mop strings and to see if washers and other parts are good and tight.

151. Moppy quickly removes all hair and string from wheels or casters because—

152. Once either hair or strings wrap themselves tightly around the moving parts on truck wheels the machine literally freezes. It just will not push and Moppy's work is made much harder.

153. Electrical scrubbing or water pick-up suction machines are useless if they are not kept in good condition. Too, such machines become obsolete very quickly unless they are kept clean and in good repair.

154. The wiring or plugs must be watched and repaired immediately they show signs of wear. No one likes to get shocks or to be blamed for short circuits.

155. Moppy is a first-rate mopper, but he is no electrician. He does not know enough about motors or cords or plugs to qualify him for an electrician's rating.

Anyway, why should he try to repair his own machine? The hospital has a good electrician who is much better qualified to repair electrical machinery than Moppy is. These are the reasons Moppy quickly takes all broken down electrical equipment to the shop.

156. There are correct ways and there are wrong ways to do every job. There are hard ways and there are ways that are not so hard. Moppy has tried to show you the best ways.

157. Not only has Moppy contributed to the health and happiness of the patients but he has also contributed to the morale of everyone in the hospital. He has had a hand in setting the background for every activity in the hospital, for everyone knows that doctors, nurses, technicians, dietitians, pharmacists, and every member of the hospital staff must have clean pleasant surroundings, so that they can best administer to the all-important patient.

158. "And in closing, I will repeat my favorite motto: CLEANLINESS IS NEXT TO GODLINESS."

(The first section of the training manual on dusting will appear in the September issue of this magazine.)

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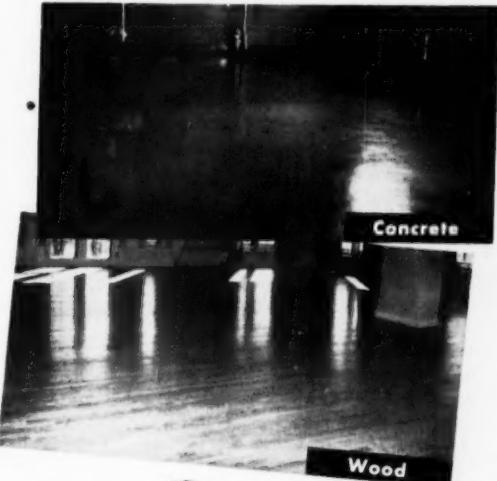


For ASPHALT TILE FLOORS . . . From now on you won't have to wax those asphalt tile floors to keep them good-looking and well protected. Multi-Clean Asphalt Tile Preserver is a complete finish in itself . . . it provides a long-lasting, glossy finish, and is U/L approved as anti-slip. It ensures continuing beauty and protection for all your asphalt tile. If you prefer to continue waxing your floors, you'll find Asphalt Tile Preserver an excellent base for wax. It makes the wax look nicer and saves you money because less wax is needed. With the *Multi-Clean Method*, ordinary dry sweeping or vacuuming and weekly damp mopping keep asphalt tile clean . . . buffing with a Multi-Clean Floor Machine equipped with a polishing brush or steel wool disc will restore the original lustre.

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For CONCRETE FLOORS . . . Two types of concrete floor treatments, each formulated to meet your own special floor condition are available to you with the *Multi-Clean Method* of floor care. Both Multi-Clean Neo-Dry Concrete Sealer (rubber-base) and Multi-Clean Concrete Preserver (bakelite-base) provide tough finishes that resist scuffing and wearing, that are not affected by water, grease, oils, or alkalies, and will not peel, chip, or fade with age. They'll give you an excellent base for wax, cut sweeping time and reduce the need for damp mopping.

For WOOD FLOORS . . . The speed and ease with which your wood floors are kept in first-class condition with the *Multi-Clean Method* will reduce your maintenance costs. Even under heaviest foot traffic, your floors will retain their safe, glossy finish for longer periods between treatments. Ordinary dry sweeping will keep them clean, and periodic polishing with a Multi-Clean Floor Machine will remove the usual surface dirt and scuff marks, restoring brightness and lustre.



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Hospitals Endure Under Socialized Medicine

(Continued From Page 62)

ister." The boards constitute "a very expensive setup," he said. "I take the view that their powers must be swept away altogether," he concluded.

Suggesting a more general approach, the *London Times* asked editorially, "How long is Mr. Macleod going to continue Mr. Bevan's penny-wise-pound-foolish policy of starving the hospitals of resources for building and labor-saving equipment? By what stages, on the other hand, does he aim to introduce rational budgeting methods into the hospitals, so that the significance of their current spending can be properly assessed?"

The Minister's answers to these last questions, at least, are plain. He intends to be guided by the findings of his independent investigating committee, the body that is viewed with such suspicious misgivings by Labor, and with such soaring hopes by Government and, probably, a majority of those in the hospital service itself. Headed by a Cambridge University economist who has expressed the view that the health service can be made more efficient without increasing costs, the committee has already undertaken its investigations.

In addition to whatever recommendations may emerge affecting hospitals, the Minister will look to his new investigating committee for an answer to one of the most perplexing problems in the whole health service—the constantly rising cost of drugs and prescriptions, which last year, in spite of a 14 cent charge to the patient for each prescription, reached the staggering total of \$169,000,000 or 15 per cent of the entire cost of the service. The development of new, expensive drugs and the increasing use of chemotherapy certainly account for a part of the increase, but the Minister is alarmed nevertheless at the growing number of prescriptions being filled and the increasing cost per prescription. Not the least of the drug problems is the large number of proprietary or brand name drugs being prescribed when, in the opinion of the Minister, at least, the

formulary equivalents would serve just as well. "I am sure that I will have the help of the medical profession," he said hopefully not long ago in talking about this aspect of the problem—a part of which he ascribed to drug firms that "batten on the health service" and are "merely wrapping up standard preparations in pretty packages and forcing them on the notice of doctors by salesmanship"—a practice that is legitimate, if somewhat extravagant, in a free enterprise economy, but which the Minister referred to darkly in his address to the House of Commons. "The government have decided that we will start a number of investigations into the cost of manufacture of certain of these proprietaries which seem at first sight to be especially expensive," he said. "I hope that this will yield substantial savings and in due course I intend to circulate again to doctors the names of those preparations concerning which we are unable to reach satisfactory agreements on prices. The action we are taking now is not to be taken as the end of the story, and I do not rule out more drastic measures if that fails."

Mr. Macleod didn't even hint at what these more drastic measures might be, but, nevertheless, this is the kind of talk that raises blood pressures in and out of the drug industry and supports the view, widely held in the United States, that socialism, like pregnancy, can be stopped at mid-term only by radical surgery.

The truth of this proposition is now being tested in Britain's health service, which was recently described by one of its best friends and severest critics, Sir Wilson Jameson, for many years chief medical officer of the Ministry of Health and now an executive of King Edward's Fund, as a "great experiment." Like Minister Macleod, Sir Wilson is optimistic and believes the problems of the service, difficult as they are, will eventually be solved without destroying, or even diminishing, its value as a bulwark to the nation's health. Sir Wilson's view of

the health service is above partisan politics, and his optimism is persuasive. The best hope that the health service will ultimately achieve its objective lies in the thousands of devoted citizens who are convinced that it can and who are devoting all their energies—in the Ministry, on hospital boards and committees, in the medical and hospital and public health services, and in interested outside agencies like King Edward's Fund—to making certain that it does.

If the great experiment should succeed in Great Britain, and certainly it has not yet failed, advocates of a national health service for the United States may be encouraged to renew their efforts, now comfortably subdued, in this country. The fact is, however, that the British experiment, in success or in failure, has no direct significance for the United States. The result of economic and political pressures which have no exact counterparts here, Britain's National Health Service emerged five years ago as the inevitable way out for a nation whose medical care problems had reached massive proportions. Whether or not we shall eventually be confronted with problems of similar magnitude depends partly on the course of political and economic events in our country and the world, and partly on the wisdom and courage with which we plan and execute our own medical programs, still predominantly voluntary. If we fail to recognize health needs and move forward to meet them, we shall unquestionably be forced one day to try an experiment of our own, regardless of what has happened in Great Britain.

Meanwhile, the aim of our voluntary system, like that of the British National Health Service, must be constant self-improvement.

"What we want to achieve," Minister Macleod said recently, "is a system whereby the health service itself has an interest in economy which is as natural and rewarding as is its interest in medical efficiency."

That's what we all want.

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Memorial Hospital's Disaster Experience

(Continued From Page 83)

tive staff have lists with them at all times of the five or six key doctors and personnel to call first, particularly the doctor who is going to screen the patients. These persons have the ability and knowledge to organize and develop the plan of action during that first 30 to 60 minutes, regardless of how well they may have been previously planned on paper. Then as others arrive, there is time to correlate them into a prearranged master plan.

Volunteers. It is advisable to have available two other persons in addition to the director of volunteers who know well the operation of this department.

School Children. As the school children were on vacation, many of them came to the hospital wanting to help. It is recommended that the school authorities organize a service program in the schools, thus keeping children off the streets and away from the hospitals during these emergencies.

Secretarial Assistance. We were impressed with the secretarial and clerical assistance. This was particularly true on the day after the disaster when the records had to be compiled. A secretary accompanied each medical team to make bedside notes of the doctor's evaluation of the patient's condition.

X-Ray. The x-ray department reported a system of film interpretation which is worthy of note. The radiologist viewed each wet film that came through the processing solution. He dictated a brief note to the resident on each case and the latter kept these notes with him at all times for immediate reference when anyone requested a report. This system is recommended. It avoids much waste time looking for individual films among the large volume of wet films that quickly accumulate.

Supplies. Although we have always been advised to have a stock pile, we cannot overemphasize the value of having adequate supplies and equipment. We found the standard army cot best for temporary wards. It is well to have more than enough of these cots ready for expansion.

Emergency Generator. We realized the need of adequate emergency gen-

erators to provide elevator service and to light corridors, stairways and strategic areas.

Disaster Wagons. Our nursing department recommends having disaster wagons available in emergency rooms and first-aid stations. These would contain an emergency supply of tags, skin pencils, intravenous baskets, medications, tourniquets and razors.

Blood Bank. Our blood bank is located in the outpatient department. This was good for administering transfusions and intravenous medications. However, the bleeding was also done in this area, adjacent to the emergency entrance. The three lines of donors waiting to be typed and bled added seriously to the congestion. We learned that the bleeding center, not the blood bank, should be away from the treatment areas.

Transportation. In a large hospital with vertical transportation, elevator service became an important factor. Careful attention should be given to building plans for more than a sufficient number of elevators. This would provide good elevator service in an emergency with express service to strategic areas such as the surgery.

Public Relations. This may not seem too important, but we advise that a post-disaster public relations officer be available in the hospital. This person should be well informed and rested with a fresh point of view. You will find after going through one of these experiences that you become fatigued and irritable. It is really harassing and tiring to have to repeat again and again in great detail to the investigating authorities the hospital's part in the disaster care. For good public relations it is advisable to have one person, not the administrator, assigned to this job after the emergency is over.

Disaster Agencies. We strongly believe it advisable and hope it may be possible in the future that hospital officials in a disaster area deal with a single agency of authority, service and investigation rather than three or four.

Disaster Education. We know that we profited directly from the education in disaster planning received during the last 10 years from the press, radio, civilian defense, and Red Cross. It was amazing how persons seemed to know what to do.

Finally, it is evident that hospitals should benefit from the experience of others and should periodically review and revise their disaster plans.

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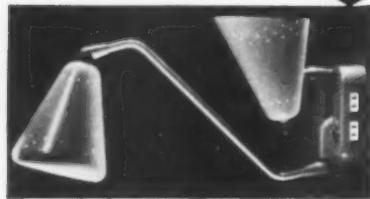


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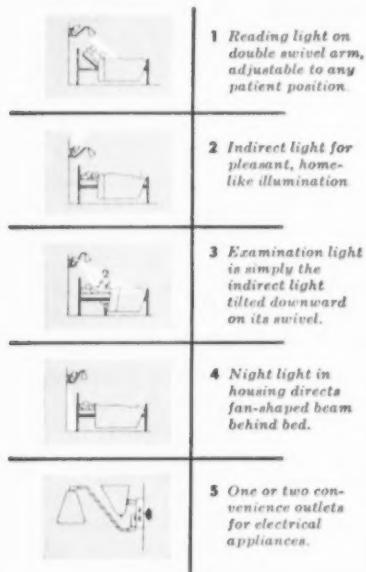
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**St. Vincent Hospital's
 Disaster Plan**

(Continued From Page 83)

with a long corridor approaching it. All materials were on hand to institute immediate treatment of shock, burns, lacerations and fractures. A team of doctors and nurses worked in each room. No attempt was made to treat the seriously injured in this area. The primary aim was to assess the extent of injury and start initial therapy. Once this was done all seriously injured patients were admitted to the wards. Each such patient was assigned a doctor who became immediately responsible for that patient.

Minor injuries were treated in the emergency surgery. Lacerations were cleansed, debrided and sutured. Tetanus antiserum or toxoid was administered. Many such patients could be discharged after such therapy.

Fracture patients were immobilized in pillow splints and sent to the x-ray department or were given x-ray examination with the portable unit, and admitted to the wards. Each was assigned a physician on admission.

There were many imponderables in the first hour but the large question in our minds was how many casualties we could expect. We had planned to discharge all ambulatory patients from the hospital as soon as the need for their beds became apparent. Fortunately the need did not develop. But we were prepared to take this step.

The second unknown was blood. We knew we would need some and that we might have to supply other hospitals. The response to a radio appeal for donors was dramatic. By 6:30 p.m. they began to appear and by 7 p.m. there was a line of 200 donors formed and blood was being drawn. At 6:30 p.m. 22 pints of blood were transferred from our bank to another hospital. Two teams were drawing blood at this time but within a half hour six teams were drawing blood. Between 6:30 and 10 p.m. 190 pints of blood had been drawn in our hospital and we called a halt. The regular blood bank technicians had typed and done Rh factors on all these bloods.

The hospital switchboard was flooded with calls and frequently it was easier to go after things than to

call for them. Too many people used the telephone unnecessarily.

The administrator's office was set up as an information and coordinating center. Here a separate telephone trunk not operating through the switchboard proved a godsend. By means of it, the information center could correlate information on blood, casualties and beds with other hospitals. Supplies could be obtained expeditiously from suppliers. A single example was the shortage of large gauge needles vital to rapid bleeding of donors. Within 30 minutes after a single telephone call, 100 were delivered to the hospital.

In all, 95 casualties arrived at St. Vincent Hospital between 6:35 p.m. and 11 p.m. Of these, 68 were minor injuries, treated immediately and dismissed; 27 casualties were admitted to the hospital for treatment. By 11 p.m. all patients had been given emergency care, and the hum of activity began to subside.

The disaster brought out a large number of people who wanted to be helpful in any way possible. The quick response of the community was little short of amazing. Charity was displayed at every turn. But such a milling crowd, eager to be helpful, can be a bottleneck and needs immediate control. It cropped up quickly when lines of blood donors almost choked the main corridor on the ground floor. This was quickly corrected by detouring the line outside the building. Traffic on the streets about the hospital was very heavy. For further planning we shall have to consider measures for emergency traffic control at all intersections about the hospital, as well as the major approach pathways.

The disaster which happened here can happen anywhere. We found it helpful to have a plan for the emergency down on paper, to have necessary supplies on hand, and to have the staff—medical, nursing and administrative—well acquainted with the plan long before the catastrophe occurred. We found flaws in our plan of a minor nature. Adjustments can be made only on the basis of experience. We have now had a small experience—when one thinks in terms of the atom bomb—but it is better than no experience at all. Now we must enlarge on our plans and improve them in the minor details, at the same time praying to God that we'll never have to use them.

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Deaths from pulmonary embolism were halved among thousands of patients using new routine at Massachusetts Memorial Hospitals

In the majority of cases, pulmonary embolism results from circulatory stasis incident to bed rest.

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A new routine, established at Massachusetts Memorial Hospitals, calls for wearing T. E. D. Elastic Stockings by bed patients as standard procedure (except in cases of ischemic vascular disease of the legs in which use of the stockings is contraindicated).

Tests of the new routine on more than 5,000 patients showed only half as many deaths from pulmonary embolism among patients wearing T. E. D. Elastic Stockings as among a control group not wearing the stockings.

For an illustrated report on continuing embolism studies, write to Bauer & Black Research Laboratories, 309 W. Jackson Blvd., Chicago 6, Illinois.

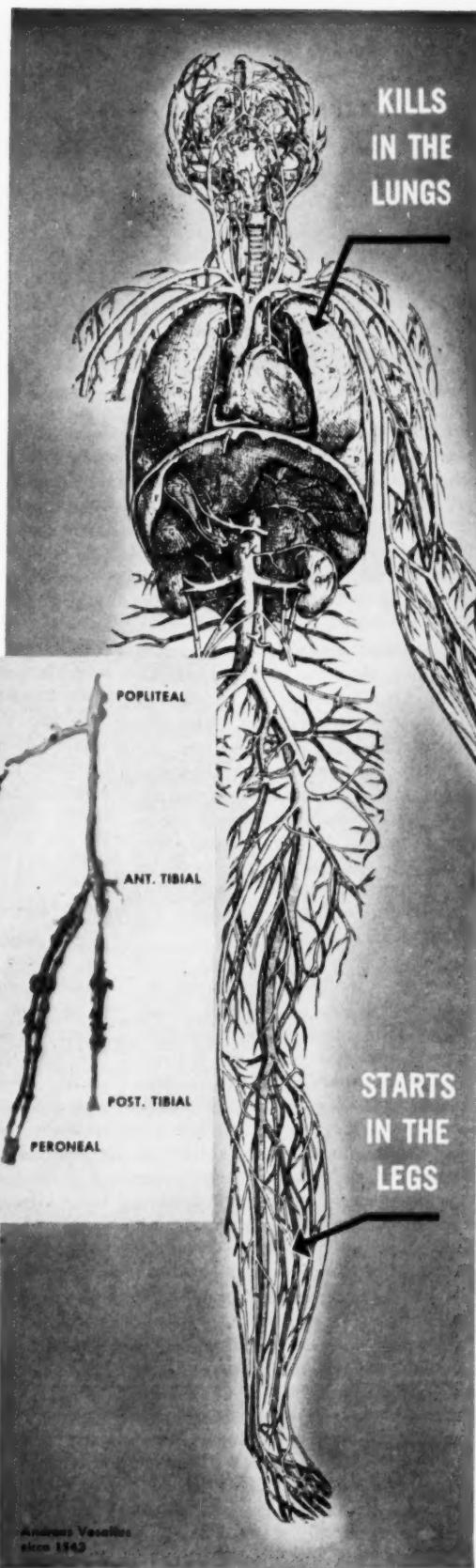
(Right)—Photo inset shows deep calf veins of pulmonary embolism victim. Note beaded appearance of veins which were filled with ante mortem clot. Note that parts of posterior tibial have greater diameter than the popliteal. Autopsy studies indicate that most fatal emboli originate from clots in the deep leg veins.



Specimen photograph courtesy of Joseph R. Stanton, M.D.,
Massachusetts Memorial Hospitals and Boston University School of Medicine.

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NEWS DIGEST

4000 Delegates Attend First N.L.N. Convention . . . Dr. Frederick T. Hill Honored at Maine Meeting . . . N.I.H. Clinical Center Dedicated . . . New Mexico Association Meeting . . . California Tax Code Amended

Emotional Needs of Patients Emphasized At N.L.N. Convention

CLEVELAND.—Whatever its advantages from the standpoint of mechanics and asepsis, the hospital is inferior psychologically to the home as an environment for childbirth, a group of speakers suggested to 4000 delegates attending the first convention of the National League for Nursing here last month.

Maternity hospitals are better equipped for emergencies of childbirth, Dr. Nicholson J. Eastman of Johns Hopkins Hospital, Baltimore, declared, but the hospitals often fail to satisfy emotional and psychological needs of the mother, he emphasized. In countries where most births are in homes, under the care of midwives, instead of in hospitals, mothers receive emotional support from familiar surroundings and family members, Dr. Eastman said.

The nurse is the key figure in the patient's emotional adjustment, and especially in recognizing and adjusting emotional factors that might damage the relationship between the new mother and infant, Dr. Gerald Caplan of the Harvard School of Public Health told the convention. The rôle of the nurse should be more akin to that of a sister of the new mother than that of teacher, Dr. Caplan suggested. He also cautioned nurses against "working out their own emotional problems on patients" by taking over the mother's rôle and becoming possessive about the infant.

Agreeing that improvement of the psychological environment in the hospital depended primarily on the co-operation of nurses, Helen F. Hallfors, assistant professor of nursing at Western Reserve University here, observed that lack of awareness of the patient's emotional problems was a common failing among nurses. Miss Hallfors proposed a plan under which mothers

of children up to 3 years old would remain in the hospital when the children were patients. "Separation from his mother, especially when he is ill, is an emotional shock to the young child," Miss Hallfors declared. "Such a shock can be minimized by admitting the mother with her child to the hospital." This plan takes into consideration the child's need for mother love along with his physical needs, it was explained.

Where the hospital is unable to admit mothers accompanying their children, Miss Hallfors suggested, at least they should encourage the mothers to spend as much as possible of the day in the hospital, helping with the child's care.

SHORTAGE RESULT OF DEMAND

The continuing nurse shortage in the United States is attributable to growing demands for nursing services rather than an actual lack or decrease in nursing personnel, Marion W. Sheahan, associate director of the league, stated. There are now 335,000 active registered nurses in the United States, it was explained, the largest number in history. "The shortage is the result of growing demands for nursing services," Miss Sheahan said. "We simply can't keep up with demands. According to estimates, 20,000 more nurses will be needed in hospitals alone by the end of 1954 if additional construction is completed and opened on schedule."

Outlining the need for nursing personnel of the armed services, representatives of the army, navy and air force nurse corps explained their recruitment programs to the convention. Every young nurse should serve a tour of duty with one of the military services, Capt. Winnie Gibson of the navy nurse corps suggested.

The need for nurses in the armed forces is urgent, Capt. Gibson said.

By an overwhelming majority, the league voted to accept practical nurses into membership. Advocates of the change emphasized the need for breaking down barriers between professional and practical nurses, indicating that the nation's need for nursing service cannot be met without the assistance of practical nurses. Elisabeth C. Phillips, chairman of the league committee on practical nursing service, urged professional nurses at the meeting to work more effectively with nonprofessional personnel and assume leadership in advancing the skills and understanding of all classes of workers in nursing service.

At a business session, Ruth Sleeper, president, reported that the league had 20,000 individual and 460 organizational members at the end of its first year of operation.

John H. Hayes Will Direct Commission on Financing Hospital Care

CHICAGO.—John H. Hayes, who retired last month as director of Lenox Hill Hospital, New York City, was appointed director of the Commission on Financing Hospital Care at a meeting of the commission's executive committee July 6. Mr. Hayes succeeds the late Dr. Arthur C. Bachmeyer as commission director.

Dr. Edwin L. Crosby, director of the Joint Commission on Hospital Accreditation, was named a member of the finance commission and a member of its executive committee, replacing Dr. Bachmeyer.

The executive committee also elected James E. Stuart of Cincinnati a member of the commission. Mr. Stuart is director of Hospital Care Corporation, Cincinnati, and chairman of the National Blue Cross Commission.



wire from Washington

HILL-BURTON

By the time this is in print the fiscal 1954 appropriations for Mrs. Hobby's Department of Health, Education and Welfare will undoubtedly be approved. But right now the seesaw between House and Senate conferees makes the final figures a matter of speculation.

The appropriations for Hill-Burton construction are holding up the conferees and the entire bill. These funds have varied almost from week to week ever since Mr. Truman's original budget went to Congress.

The Hill-Burton funds for authorization perhaps have taken the most drastic rides on the financial rollercoaster. Mr. Truman requested \$75,000,000 for authorization; Mr. Eisenhower lowered the figure to \$60,000,000; the House committee went along with the Eisenhower figure; the House cut it to \$50,000,000. Then the Senate took up the H.E.W. bill, with the Senate appropriations committee raising Hill-Burton funds back to \$60,000,000. The Senate overruled its committee to accept the Truman figure of \$75,000,000.

Thus House and Senate conferees met on the entire bill—there were sharp variations in many respects between the House and Senate versions—to work out a compromise. After two meetings it became evident that they had reached agreement on every item except the amount for Hill-Burton funds. Senate members clung to the \$75,000,000 figure, but House conferees would not agree to this much money, insisting on the \$50,000,000 they had suggested or, at the most, the \$60,000,000 figure in the Eisenhower request.

All through this shuffling ran a strain of discontent with the program for the first time in its history. The House committee was displeased with the operation of the program and cut funds for the Hill-Burton staff from \$1,200,000 to \$750,000 because it disapproved of field technicians' going to states to check on equipment used in the hospitals constructed. The Senate approved \$1,000,000 for the staff. The Senate committee was displeased with the split-project method of financing and recommended "that should such method be continued, there must be a clear understanding that this does not constitute a moral commitment for the Congress to provide additional funds and that the local sponsors may start building only with the understanding that they may have to provide the full amount necessary to complete the projects."

V.A. HEARINGS

Harvey B. Higley of Marinette, Wis., has been appointed Administrator of Veterans Affairs, succeeding Carl Gray Jr., who resigned last month. Administrator Higley's appointment was confirmed by the Senate July 21.

Although the question of medical care for veterans' non-service connected disabilities did not come up in the Senate discussion on the Veterans Administration's appropriation

bill, the ramifications of the Phillips rider to this measure in the House are still being felt. While the rider was defeated, the House veterans' affairs committee's subcommittee on hospitals held open hearings on the whole question of hospitalization for nonservice connected cases, inviting veterans organizations, the Veterans Administration, American Medical Association and others interested to present their views.

The results are reflected in the subcommittee's expressed displeasure with various witnesses and the prospects for congressional action next session. Rep. Olin Teague (D-Tex.), who had introduced a bill incorporating the provisions of the Phillips rider, introduced a second bill that would allow the V.A. administrator to determine the individual veteran's "ability to pay" rather than allowing the veteran to determine this himself as in the present law. This bill would also allow the administrator to admit nonservice connected cases on a priority basis, with the chronically ill getting first place as beds were available.

The A.H.A. witness, William S. McNary, chairman of the association's council on government relations, told the subcommittee: "Congress should enact legislation requiring establishment of methods for determining which veterans with nonservice connected disabilities are in greatest need and thus eligible for care." He recommended that "an advisory committee should be authorized to consist of persons experienced with this problem to assist the Veterans Administration in development and administration of regulations for the determination of financial need." Mr. McNary contended that present V.A. facilities were sufficient to care for any anticipated service connected cases and that expansion of V.A. hospital construction would be for care of nonservice connected cases only. The size of the V.A. hospital program threatens the efficiency and quality of care given service connected cases, he said.

He also pointed out that "until Veterans Administration hospitals were opened to nonservice connected cases, it had been traditional in our society that states and local communities were responsible for medical and hospital care of persons unable to pay for it," including veterans. Mr. McNary said this was the system favored by the association although, he agreed, some states were unable to care for all chronically ill veterans. He said that if present V.A. beds will not meet the needs for veterans as clarified by Congress, "Congress should consider limiting care in accordance with beds now available to the most needy veterans or should consider payment for such care on a state and local basis." In any event, "there should be no further expansion of the Veterans Administration hospital system," he said.

The subcommittee, in effect, told the veterans organizations to discuss the matter of abuses of the "ability to pay" oath and all phases of care for the nonservice connected at their national conventions this fall and come up with a firm solution—or else. Subcommittee Chairman Pat Kearney

and others scolded the veterans groups for talking in "generalities" and quibbling among themselves as to whether new legislation was needed or whether stricter interpretive regulations could solve the problems. While they all claimed the percentage of abuses was insignificant and that nonservice connected cases were not filling V.A. hospitals unnecessarily, the veterans organizations varied in their estimates of the percentage of abuses among nonservice connected cases from about 2 to 10 per cent.

The A.M.A. witness, President-Elect Walter B. Martin, and several others questioned "that Congress ever intended that the medical program of the Veterans Administration should develop to its present size." These representatives of professional groups argued that medical care for the service connected disabled was an obligation but care of veterans with nonservice connected illnesses was not—that these men had no "lien" on the federal government. They urged that Congress give the administrator power to look behind the "inability to pay" oath and open beds only to indigent nonservice connected tuberculosis, psychiatric and neuro-psychiatric cases which could not be cared for by the community or state.

On the question of V.A.'s caring for nonservice connected cases and collecting a fee from those able to pay, Dr. William Walsh, National Medical Veterans Society witness, said: "We do not feel it is either feasible or desirable to have the government collect any fees for care. . . . There seems to be no controversy on this subject among the interested groups, for its dangers and ramifications are self-evident."

Veterans Administration testimony pointed out that some changes could be made by regulation, although it favored no change in the present system. Acting Administrator H. V. Stirling said not caring for certain of the nonservice connected cases would be "a substantial reversal of long existing legislative policy" and claimed that more stringent eligibility requirements would create "administrative burdens and delays of such magnitude as to render the more rigid requirements unsupportable."

COMMISSION ON DEPENDENTS

The Citizens Advisory Commission on Medical Care of Dependents of Military Personnel—a group with a long name and a short life—has made its report and passed from the Washington scene. Once its report had been filed with the Secretary of Defense, the high powered, five-man commission disbanded, less than 100 days after it first went to work. While the effects of the recommendations this group made are slow in coming, they are sure to come, because the group called upon Congress to "make an explicit declaration of policy with respect to dependent medical care in order that existing uncertainties and inconsistencies may be removed."

The commission concluded that medical care of dependents was a part of military medicine by virtue of personnel policy rather than right. They urged that it be given to all dependents, once Congress has decided just who is and who is not a dependent. The report used as a premise "that medical care for dependents—within prescribed limits—is sound national policy" and recommended care for all, regardless of location. Under the commission's plan dependents would get care first at military installations, but, when that was impossible, care would be given at local hospitals by local physicians with the military picking up the bill.

The commission estimated the additional costs at between 30 and 40 million dollars a year and advocated a separate budget item for dependent care. The safeguard the commission would require is a token fee to be paid by the patient to avoid "running to the doctor for minor ailments, real or imaginary."

Under the present system dependents receive medical care only in military installations on a "first come, first serve" basis, with about 60 per cent of all dependents receiving some sort of treatment. The commission reasoned that all dependents were entitled to this care if some were and concluded that the patients should be treated irrespective of their proximity to a military hospital or clinic. There are an estimated 2,700,000 military dependents; about 82 per cent of the officers have one or more dependents, while only 36 per cent of the enlisted men have dependents.

Present medical care is given to dependents of military personnel on the basis of a law passed in 1884, when fighting Indians was military duty, and the commission urged Congress to take a stand and clear the air: "Legislation should state what types of illnesses will be treated, whose dependents are eligible, and what types of dependents are entitled to medical care."

The commission ruled out an increase in pay in lieu of medical care for dependents because "(1) It would be costly, because it would necessitate an increase in the pay of all personnel with dependents, irrespective of illness. . . . (2) No feasible scale of increased pay would take care of any major illnesses. . . . (3) It would not be as valuable from a morale point of view as the present system. . . . (4) Many thriftless and shortsighted individuals would have spent the money on other things, leaving their dependents still to be cared for."

The American Hospital Association's plan to incorporate dependents in group insurance plans was ruled out because it "is preoccupied with the draftees rather than with career servicemen . . . who constitute the hard core of the military . . . and whose medical needs present . . . a continuing problem."

The commission wrote off the view of the American Medical Association that medical care of dependents should be reduced as "a direct outgrowth of the cold war and the Korean conflict, which has necessitated drafting doctors" and predicted that the association's objections would disappear once the doctor draft law was no longer necessary.

NOTES:

Veterans Administration reorganization, in the mill since former Administrator Carl Gray announced the plan last winter, is due to take effect September 7. The plan, outlined at the time the controversial Booz, Allen and Hamilton report on V.A. organization was issued, divides the agency into three operation units—medicine and surgery, veterans benefits, and insurance. V. Adm. Joel T. Boone, chief V.A. medical director, has been appointed medical director under the new setup. His department carries the functions of the old Special Services branch as well as those of the original Department of Medicine and Surgery. In explaining the effect of the reorganization, Acting Administrator H. V. Stirling said: "There will be fewer officials reporting directly to the administrator; staff and operating responsibilities will be clearly separated at all levels and there will be increased delegations of authority to the field."

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NEWS...

New Mexico Association Presents Merit Awards for Service to Hospitals

ALBUQUERQUE, N.M.—William L. Gold, administrator of Las Vegas Hospital, Las Vegas, was named president-elect of the New Mexico Hospital Association at its eighth annual meeting here May 22 and 23. George Brewer, administrator of Roosevelt General Hospital, Portales, became president during the meeting.

Other officers elected were: vice president, Harry Miller, Memorial General Hospital, Las Cruces; secretary-treasurer, Homer A. Reid, Lovelace Clinic, Albuquerque, and trustee, Sister Mary Adolpha, administrator, St. Francis Xavier Hospital, Carlsbad.

The association set an attendance record with almost two hundred people on hand, approximately double previous registrations.

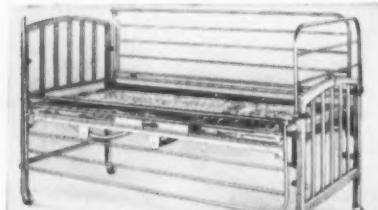
In a talk dealing with the economic stability of hospitals, Mr. Brewer said a few hospitals in the state have had to close for lack of operating funds and that present prospects seem to indicate other hospitals might be forced to close their doors. Some commun-

ties, basing their hospital needs on prosperity and the economic growth of the Forties took advantage of Hill-Burton, he observed, without taking into account the population decline which has been taking the place of the expected rise.

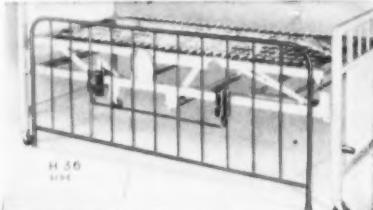
F. O. McVey, administrator, Clovis Memorial Hospital, attributed the money crisis to "lack of prepaid medical insurance and inadequate payments from the state welfare department in indigent cases." He said the solution is to promote hospitalization insurance and legislation that would increase welfare assistance.

Chapin S. Carnes, president of the Credit Bureau of Albuquerque, suggested that hospitals increase their efforts to collect delinquent accounts as a partial cure for their deficits.

Women's auxiliaries participated in the program of the association for the first time, and an audience of about 60 heard the address of Mrs. Lee Tollefson of Los Angeles. The auxiliaries also conducted a workshop, discussing fund raising and other ways and means of assisting hospitals. Mrs. A. C. Rood of Albuquerque was appointed coordinator of the meeting.



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New Mexico officers, l. to r.: Sister Mary Adolpha, trustee; President George Brewer; President-Elect W. L. Gold; Vice President Harry Miller; Secretary-Treasurer Homer Reid.

Awards of merit were presented to C. Robin Jacobsen, director of the New Mexico Blue Cross Plan, and Mary Jane Carter, former president of the New Mexico Nurses' Association. Similar awards will be made annually "to reward those who devote their energy to helping hospitals do a better job, and to call to the public's attention that hospitals are in need of and do appreciate help from the lay public," according to an association official.

\$10,000 Research Fund Honors Dr. Tanchester

NEW YORK.—Dr. David Tanchester, chief of the dental department of Montefiore Hospital here for more than 30 years, was the guest of honor at a dinner on June 18, commemorating the establishment of the hospital's dental clinic. As a tribute to him, a fund exceeding \$10,000, to be known as the David Tanchester Research Fund, was presented to the hospital.

Dr. Tanchester, a member of the hospital's medical board and its secretary for 10 years, helped organize the first modern dental clinic in a general hospital, according to a hospital announcement. The clinic, which now has a staff of 35, conducts a teaching and research program in addition to serving the hospital's patients.

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A greaseproof floor tile manufactured especially for industrial areas subjected to grease and oil abuse. Tuff-Tex takes heavy plant traffic, lubricating oils, food and kitchen greases. It withstands rolling friction including reasonable trucking abuse.

Tuff-Tex can be installed on grade or below grade and over wood or concrete.

Other industrial features: fire-resistant . . . not affected by moisture . . . safe, sure walking surface . . . high flexural strength . . . high impact resistance . . . easy to install and alter.

Tuff-Tex is available in attractive colors that will brighten up drab factory interiors. The choice of colors and sizes makes many functional designs possible. Comes in 1/8", 3/16", and 1/4" thicknesses.

TILE-TEX ASPHALT FLOOR TILE

Tile-Tex is a low-priced, high-quality asphalt tile. It combines beauty with durability, minimum maintenance, and long service.

It has a long established reputation for satisfactory performance. Ideal for schools, stores, homes, and wherever a good, but economical tile is desired.

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and a full line of accessories—30 attractive colors, 6 sizes, and 1/8" and 3/16" thicknesses.

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A new flexible tile wall covering in 3/32" thickness. Ideally suited for commercial and industrial wainscoting and walls. Mura-Tex is greaseproof. Resists acid and alkalis. Can be installed directly on either new or old plaster walls, or properly constructed dry wall construction.

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This coved sink counter of Parkwood Post-Form eliminates dirt-catching crevices. Also available with rolled front edge. Ideal for kitchen, pantry or lab.

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PARKWOOD DECORATIVE — Rich tints, lovely pastels, in solid colors, intriguing patterns or wood grains, protected by beautiful, mirror-smooth Melamine from damage by alcohol, boiling water, common acids and alkalies. Minimum cleaning and maintenance worries.

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NEWS...

Dr. Hill Honored With Life Membership at Maine Hospital Meeting

BELGRADE LAKES, ME.—Dr. Frederick T. Hill, medical director of Thayer Hospital, Waterville, was presented an honorary life membership in the Maine Hospital Association "in full recognition of his long and complete dedication and untiring efforts in promoting and advancing the interests and objectives of the hospitals of Maine," during the association's annual convention on June 26.

Frank C. Curran, director of Eastern Maine General Hospital, Bangor, received a testimonial certificate for his many "worth-while activities in behalf of Maine hospitals over past years, and in particular, for his singular efforts in our cause at the legislature during recent months," where, according to talks given by several of the convention's speakers, state aid to hospitals has been much discussed lately.

Possibility that the state may withdraw its policy of aid to public and private hospitals was advanced during the first afternoon session. According to reports the aid now amounts to more than a million dollars annually. Maurice F. Williams, assistant to Maine Finance Commissioner Raymond Mudge, who substituted for Mr. Mudge, told association members that "it is the thinking of some legislators that a law should be presented requiring the local communities to reimburse the hospitals for the actual costs of charity patients who have legal residence in the communities.

"It is felt that through this process the hospitals would get more money to work with, inasmuch as the hospitals would be reimbursed at the rate of their actual per patient day cost, not at the ward rate charge.

"It is also felt that by passing this load back to the local communities, it may have the effect of reducing the number of charity patients admitted by direction of their physicians," Mr. Williams declared.

Mr. Curran stressed the importance of uniform reporting in relation to state aid and third party purchases in his discussion of accounting and reporting.

In her annual report, Sister M. Annunziata J., retiring president of the association, said the association's chief problem was obtaining an increased

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IT'S DUCK SOUP MAINTAINING OUR RUBBER TILE FLOOR WITH LUSTRECLEAN. ONE PASS WITH THE MOP, AND YOU CLEAN AND WAX AT THE SAME TIME

WHENEVER THE JANITOR MADE WITH THE BROOM, IT USED TO LOOK LIKE A WINDY DAY IN THE DUST BOWL. WESTONE CHANGED ALL THAT ! NOW HE MAKES A CLEAN SWEEP WITHOUT A SINGLE "GESUNDHEIT."

THAT FAST-BREAKING BASKETBALL TEAM OF OURS ALMOST HAD US BROKE 'TIL WE LEARNED ABOUT WEST'S LASTINCOTE SEALER. NOW OUR GYM FLOORS JUST SNICKER AT SNEAKERS !

FIRST TIME I'VE EVER SEEN THESE GUYS AGREE ON ANYTHING ... BUT THEN EVERYBODY AGREES THAT WEST'S THE BEST FOR FLOOR CARE

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TYPE OF FLOOR	INSTALLED COST* OF 50,000 SQ. FT.
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Marble	150,000

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ball-bearing Casters**
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Bed Panels
of 5-ply laminated
wood construction
with stainless steel
channel protecting
the top edge

**Shipped Completely
Assembled** with
exception of head
and foot panels



This new Hill-Rom No. 60 Motor-driven High-Low Bed combines many new design and construction features that make for increased safety, time-saving convenience and long service life. The motor and gear reduction unit, for example, are designed and rated for a minimum service life of 10 years constant service, based on 10 hours per day seven days per week. Under the most extreme circumstances these units would seldom—if ever—be in actual operation more than 30 minutes daily.

The 5-ply laminated wood panels are furnished in pencil stripe walnut, rift oak or Korina finish, and are attached to the bed by means of stainless steel clips. The bed is equipped with large ball-bearing casters, with brakes on two wheels.

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HILL-ROM COMPANY INC., BATESVILLE, INDIANA

NEWS...

state aid appropriation. She added that a "major success was achieved," since this year's legislature raised the current aid figure of \$800,000 to \$1,100,000 annually for the next two years.

Dana Thompson, director of Central Maine General Hospital, Lewiston, became president during the meeting. Other officers elected were: vice president, Neil Bunker, administrator, Bar Harbor Hospital, Bar Harbor; secretary, Lawrence MacDougall, Eastern Maine General Hospital, Bangor, and treasurer, Garner Goodwin, administrator, Waldo County General Hospital, Belfast.

Secretary Hobby Dedicates \$64,000,000 Clinical Center of Institutes of Health

WASHINGTON, D.C.—An estimated 4000 persons toured the new 500 bed Clinical Center of the National Institutes of Health, Bethesda, Md., following its dedication on July 2. Speaking at the dedication of the combined hospital-laboratory building, Mrs. Oveta Culp Hobby, Secretary of Health, Education and Welfare, stated: "The center will house the widest array of specialists and technicians that has ever in the history of mankind been assembled to work in pure and applied science."

The 14 story building comprises 1100 laboratory bays and 500 beds for the patients who will be studied by the Clinical Center staff. The ground and top floors of the structure are allocated to such services as admission centers, operating rooms, auditorium, gymnasium and chapel, while the intervening floors house both patients and the laboratories. Patients' rooms are located on the south side of the main stem of the building, which is shaped like a modified Lorraine cross, while the clinical laboratories occupy the north side. In the center are the service areas, i.e. nurses' stations, floor kitchens, and treatment rooms. The basic science laboratories are in the wings of the structure. Radiation facilities will be grouped in one eight-story wing, scheduled for completion in January 1954. When finished it will contain all modern atomic energy means of treating patients, as well as laboratories for the preparation of medications containing radioisotopes. An unusual feature of the radiation wing is the provision

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The new American all-purpose Junior Autoclave. This new model provides 22% greater cubical capacity than cylindrical types, therefore accommodates two instrument trays instead of one.

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NEWS...

of rooms for patients, which will make possible supervised control of radio-isotopes for diagnosis and treatment.

Inasmuch as many of the patients will be ambulatory, provisions have been made for rooms that resemble hotel rather than hospital accommodations. All rooms are semiprivate and each has its own bathroom. An intercommunicating system permits the nurses to talk to patients from the nurses' station.

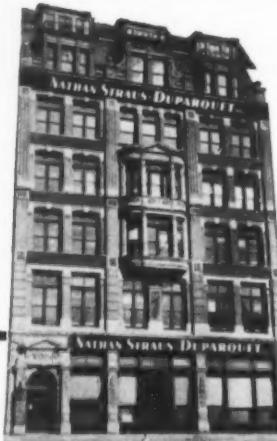
Emphasis at the Clinical Center will

be on the study and treatment of such common killers and cripplers as heart disease, cancer and arthritis. Patients, all of whom will come in on a voluntary basis, will be referred for study by their own physicians. "Only persons recommended by physicians, hospitals or medical schools will be admitted," Dr. John A. Trautman, director of the Clinical Center, said. "Most of these will come from the eastern seaboard, to make follow-up studies easier, and nearly all will come to fulfill a special

requirement." Dr. Trautman's statement was echoed by Dr. W. Henry Sebrell Jr., director of the National Institutes of Health, who added: "For the first time in history, we will be able to integrate laboratory research so that there can be a complete study of the chronic diseases that kill men."

The first patients were admitted to the hospital on July 6 and it is expected that 250 will have arrived by June 1954. The Center will not be in full operation, officials explained, for two or three years as physicians, scientists, laboratory experts and therapists pioneer in new administrative and medical technics.

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Left to right: Charles E. Varney, Robert S. Hoyt, Edyth Barnes, Richard R. Griffith, Brady J. Dayton.

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No other medication cart can save you up to 53% in medication time . . . make such easy, safe deliveries to bedside . . . save nurses so much time and work!

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1 24 complete oral medications are prepared at one time. Both the medicine glasses and the patients' medicine cards are placed in permanent holders for accurate, safe identification.

3 The racks slide into the drawer for transit. Syringes are held level and firm by both spring clips and sponge trough. No danger of medication leakage or sponges falling off. Medication and cards remain *precisely* as placed until ready for the patient.

2 24 loaded hypodermic syringes are placed in special racks. Each syringes protected by an acceptable safe aseptic technique and properly, safely marked by the patient's own medicine card.

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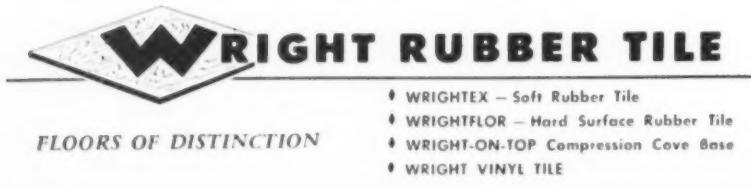
These advantages—silence and sanitation—make Wright Rubber Tile the ideal floor covering for hospitals. But in addition, it is the longest wearing, most comfortable, most beautiful floor you can get.

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NEWS...

World War II that truly brought the practical nurse into being in the hospital program.

"Although recognition has been extremely slow in coming," he stated, "practically all agencies now consider the practical nurse an important unit on the team necessary to provide care for the sick in our hospitals and homes."

"When we set up our school for practical nurses, we had some very positive limitations as to what the graduates would be permitted to do. That was fine in theory, but in practice it did not work. We found ourselves with patients and none but practical nurses to care for them. They did a grand job. We are convinced that with supervision there need be very little in the way of limitations."

Other speakers on the morning program were Sara F. Gibson, acting executive secretary, Delaware Board of Nurse Examiners, and Virginia Layfield, director of nurses, Peninsula General Hospital.

Miss Gibson described the barriers and difficulties imposed on the registered nurse by state lines and absence of standardization in examinations from state to state. She expressed the hope that further gains in reciprocity between states would be made.

Mrs. Layfield, speaking on "Nurse Education From the Viewpoint of the Three-Year School," emphasized that the standards of nursing care in the hospital with which the school is associated must be high in order to provide good learning opportunities for student nurses. She suggested that the provision of scholarships and loans will make it easier for more young women to enter nursing.

Robert S. Hoyt, administrator, Lutheran Hospital of Maryland, Inc., Baltimore, and president-elect of the association, presided at luncheon. Edyth Barnes, division of nursing services, Federal Security Agency, Washington, D.C., spoke on "Degree Courses for Nurses" and told the conference that there is a distinct need for increasing both diploma and degree programs.

The afternoon session was devoted to group discussions on the regional approach to nursing education and the utilizing of resources for better patient care.

Mary A. Maher, director of the nursing education program at Boston University School of Nursing, described the regional program of the Bingham



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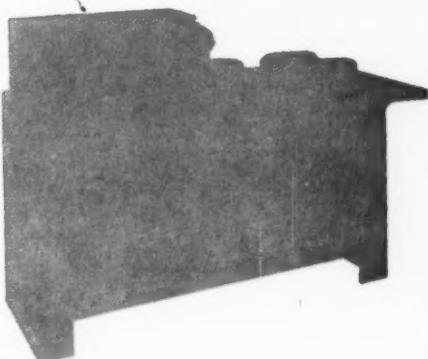
are the imitations really as good?

Science recently produced an imitation diamond equal in all respects to the natural stone. Yet the diamond market remained undisturbed. Why? Because this achievement, while a scientific success was an economic flop. The imitation diamond cost many times more than the natural stone!

Repeated over and over again, this example is the history of imitations. In order to stay competitive in price, something must be left out, corners must be cut to reduce costs.

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NEWS...

Associates, a cooperative group of 44 New England hospitals, which, she said, has resulted in a "continuous upgrading of nursing practices."

Members of the conference indicated their approval of the regional approach in order that the smaller hospitals and nursing schools might have the opportunity to share the facilities and resources of the larger institutions and have the benefit of the larger staffs of qualified instructors and specialists.

The association voted to appoint a committee to study the regional system and to determine how it could be best applied to the Maryland-District of Columbia-Delaware area.

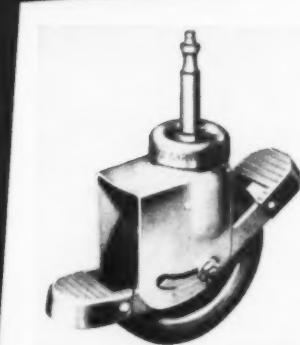
Richard R. Griffith, director, Delaware Hospital, Inc., and past president of the association, was chairman of the afternoon session.

California Tax Code Amendment Will Save Hospitals \$750,000

SAN FRANCISCO.—California hospitals were saved an estimated \$750,000 a year when the state legislature passed an amendment to the Revenue and Taxation Code affording tax relief to nonprofit hospitals, E. E. Salisbury, executive vice president of the California Hospital Association, which sponsored the amendment, reported last month. "The bill affords adequate exemption to all nonprofit hospitals," Mr. Salisbury said. "Opposition was encountered, because the loss in tax revenues amounted to as much as \$100,000 in individual counties."

Experience with the tax legislation indicated a need for improvement in the public relations programs of hospitals, Mr. Salisbury stated in a bulletin to member hospitals of the association. "Our experience indicates there is a complete lack of public understanding of the nonprofit status of the modern hospital, its financing and responsibility to the community," the bulletin said. "The definition of a nonprofit corporation must be clarified so that the public will understand that no individual or group of individuals profits from the operation of such an institution. 'Charity' and 'nonprofit' are words which are historically confusing and misleading. Any surplus or so-called 'profit' used to further the charitable objectives of the hospital should be encouraged. Perhaps we in the hospital field are too close to the

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purer than water from which it's made—
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without getting its amazing advantages. Look at the
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It needs so little space (only 24 inches in diameter),
and you install it right where you use it. A simple
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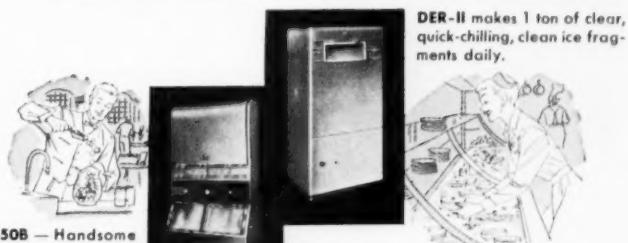
And operating costs are *more* than returned in
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Your nearby York Distributor can give you
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NEWS...

woods to see the trees. We know that no one profits and we worry to keep the per diem cost within reason. Why not share our concern with the public?"

The association also helped to defeat a bill which, if passed, would have eliminated the exemption of nonprofit hospitals from the state unemployment and disability insurance program. This would have cost hospitals in excess of \$1,000,000 annually in additional taxes, it was explained.

Begin Construction of First U.M.W. Hospital at Beckley, W. Va.

BECKLEY, W. VA.—Construction was undertaken here last month on the new Beckley Memorial Hospital, first of 10 institutions to be built by the Memorial Hospital Associations sponsored by the United Mine Workers of America Welfare and Retirement Fund. Ground for the 200 bed hospital at Beckley, designed by Sherlock, Smith and Adams of Montgomery, Ala., in cooperation with the fund staff, was broken July 4.

Speakers at the ground-breaking ceremonies were Dr. John T. Morrison, assistant executive medical officer of the fund and president of the Memorial Hospital Associations; Dr. Fred D. Mott, medical administrator of the associations, and Dr. Deane Brooke, administrator of the fund office at Beckley.

Beckley Memorial Hospital is a key unit in the group of healing centers to be built in the heart of the bituminous coal country, the speakers explained. The main building will have a capacity of approximately 200 beds, with a floor area of 107,000 square feet. Service facilities will occupy the central structure, with the wings devoted to rooms for patients.

Four operating rooms and two delivery rooms will be furnished. Apart from the hospital proper, there will be a large, one-story outpatient clinic adjacent to the main entrance and registration area. X-ray, laboratory and other medical service departments will serve both clinic and hospital patients. A department of physical medicine will undertake to restore the disabled to useful activity.

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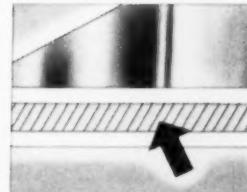


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NEWS...

nurses and technicians. Another building will house the school of practical nursing and student dormitory. A large pay cafeteria will offer complete meals and short orders to patients visiting the clinics, visitors and staff.

Indiana Association Elects New Officers

INDIANAPOLIS.—Ralph M. Haas, administrator of the Montgomery County Culver Union Hospital of Crawfordsville, was named president-elect of the Indiana Hospital Association at its annual meeting here recently. Mrs. Dorothy G. Adams, administrator, Gibson General Hospital, Princeton, became president during the meeting.

Other officers elected were: vice president, Sister Justina, administrator, St. Mary's Hospital, Evansville; treasurer, Maude M. Woodard, administrator, Clinton County Hospital, Frankfort; executive secretary, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville, and assistant secretary, Mrs. Albert G. Hahn, assistant administrator of the Protestant Deaconess Hospital.

Hannah Rosser, administrator, Vermillion County Hospital at Clinton, and Clayton E. Mann, administrator of the Baptist Hospital, Evansville, were elected to the board of trustees; Olive M. Murphy, administrator of the Bartholomew County Hospital, Columbus, will fill the unexpired term on the board brought about by the retirement of Mrs. Rinda Raines.

Hopper Fellowship Awarded in Fifth Annual Contest

NEW HAVEN, CONN.—The fifth annual Magnus T. Hopper fellowship was awarded to Avery C. Faulkner, a student in the school of architecture at Yale University, according to a recent university announcement.

The fellowship, established in 1949 under the sponsorship of Charles F. Neergaard, hospital consultant, is given annually by the Yale University department of architecture.

The Hopper competition was started at Yale as a basic hospital planning problem but has been broadened for the last two years to include all aspects of health planning, hospitalization, home care and recreation in a hypothetical American town or city.



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NEWS...

Dr. Rappleye Warns Against Law Creating "Internship Mills"

NEW YORK.—A new state law eliminating educational requirements for interns and residents serving hospitals in New York State and changing licensure requirements for interns and residents was characterized as "anti-American" by Dr. Willard C. Rappleye, dean of the College of Physicians and Surgeons at Columbia University, in a statement released here last month.

Dr. Rappleye said the new law, which was passed by the state legislature and signed by Governor Dewey last month, would create "internship and residency mills." He warned hospitals that they may be liable to malpractice suits if they employ interns and residents from unapproved medical schools, as the law now permits.

The law, passed last March 21 and effective July 1, eliminates educational requirements for all interns and many residents serving in hospitals in New

York State, and further provides that aliens in the United States under non-immigration visas, and interns and residents in state or municipal institutions do not need temporary state licenses in order to hold internship or residency appointments.

The effect of the law will lower medical standards throughout the state, Dr. Rappleye charged, characterizing the move as "a way to get cheap medical labor" for hospitals which cannot meet the educational requirements for approved internship and residency programs.

"It is clear that there is no intention to conduct these internships on an educational basis," Dr. Rappleye said in his annual report. "Some other term should be used for the employment of these individuals than that of calling them interns or residents. No solution should be advocated that would destroy the worth-while educational plan developed during recent years."

Dr. Rappleye said the effect of the law would be to invite a flood of graduates of unapproved schools into the state. "New York has taken an easy short cut to meet an immediate and difficult situation in some hospitals," he added. "Following the course of least resistance is a surrender to mediocrity, and in the long run is no solution at all."

P.H.S. Schedules Courses on Control of Diabetes

WASHINGTON, D.C.—A series of six courses in diabetes control will be held at the Diabetes Study and Training Center in Boston, it has been announced by the division of chronic disease and tuberculosis of the U.S. Public Health Service.

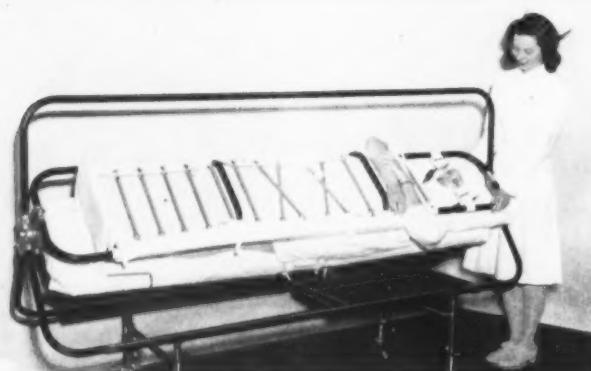
The courses will consist of discussions, demonstrations, and field trips, with opportunities for individual consultation. They have been designed for public health administrators, physicians, nurses, health educators, dietitians, nutritionists, medical technologists and medical social workers. According to the report, only two courses have been scheduled; periodic announcements will be made when others are to be held.

The courses will cover the following subjects: (1) diabetes program in public health (September 21 to 25); (2) group teaching of patients (May 25 to 29, October 5 to 12, No-



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NEWS...

vember 30 to December 4); (3) nursing aspects of a public health diabetes program (dates to be announced); (4) nutritional aspects of a public health diabetes program (dates to be announced); (5) laboratory aspects of a public health diabetes program (dates to be announced), and (6) organization and management of a diabetes clinic (dates to be announced).

The announcement stated that applications must be received one month in advance of the course dates; enrollment will be limited to 10 persons.

Canadian Group Holds Congress in Montreal

MONTREAL. — Representatives of Catholic hospitals throughout the Province of Quebec assembled in Montreal June 22 to 24 for the 19th congress sponsored by Le Comité des Hôpitaux du Québec. Some 3000 hospital people registered during the three-day sessions to hear current problems discussed by Canadian and American hospital authorities. Two topics occupied the major attention of the group; first, the hospital's responsibility in training registered nurses and practical nurses or nurses' assistants and, second, the relationships between boards of governors and administration. Lively discussion centered on proposals on the one hand to reduce the licensed nursing training period to two years, and on the other hand to offer 18 months' training courses for practical nurses.

Relationships between trustees and administration can be and should be improved, it was agreed, by greater understanding on the part of each as to the precise functions of the other. As usual a fine array of exhibits received much attention from visitors who took advantage of the hour's interruption in both morning and afternoon sessions to tour booths which lined the spacious hall of Saint-Laurent College. A feature of the opening day were decorations bestowed upon Rév. Mère Marie de Sainte-Jeanne de Chantal, director, Pavillon des Convalescents, Sillery, Que., and to M. l'abbé Victorin Germain, president, Catholic Hospital Council of Canada by Rév. Père Hector-L. Bertrand, president, Comité des Hôpitaux du Québec. Representatives from the States participating in the meetings



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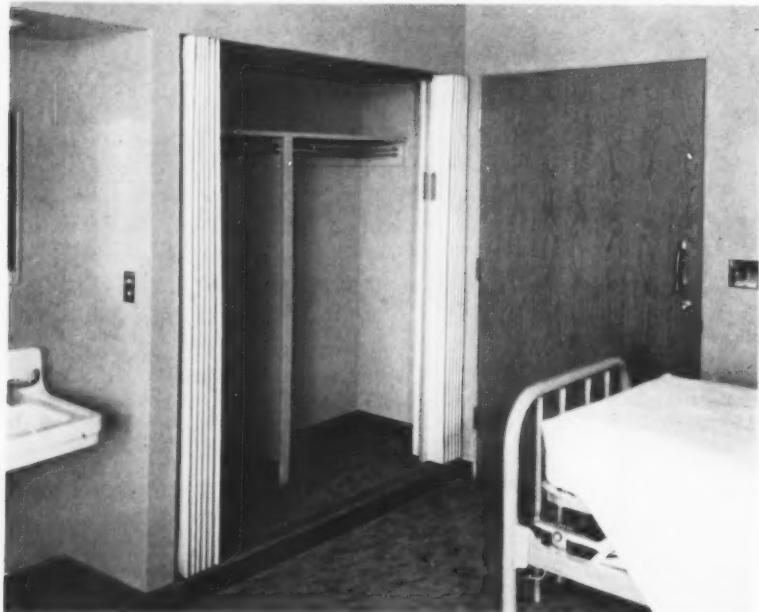
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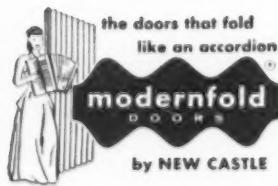
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NEWS...

were Dr. Edwin L. Crosby, secretary, Joint Commission on Accreditation of Hospitals and president, American Hospital Association; Dean Conley executive director, American College of Hospital Administrators; Dr. Malcolm T. MacEachern, director of professional relations, American Hospital Association, and Raymond P. Sloan, president of The Modern Hospital Publishing Company.

Study of Turnover Among Administrators Under Way

CHICAGO.—A study of hospital administrator turnover in recent years is now being conducted by the Commission on University Training in Hospital Administration, in collaboration with the American College of Hospital Administrators.

The prime objective of the commission, which is financed by a grant from the Kellogg Foundation, is to evaluate the existing graduate courses in hospital administration with a view toward making recommendations for the improvement of the activities of each university program. The commission was set up by the course directors of university programs.

Through this related study, it is believed that three important points will be determined: (1) an estimate of the annual demand for hospital program graduates for the next 10 years; (2) identification of the present source of supply of hospital administrators, and (3) a knowledge of the tenure and reasons for mobility of hospital administrators.

Questionnaires are being mailed to all hospital administrators throughout the United States, which are to be filled out and returned to the headquarters office of the A.C.H.A. for tabulation. It is hoped that through these opinions and observations the accuracy of the findings may be assured.

A.C.H.A.'s New Regents

CHICAGO.—Dr. T. Stewart Hamilton, director of Newton-Wellesley Hospital, Newton Lower Falls, Mass., and Harold T. Prentzel, administrator of Montgomery Hospital, Norristown, Pa., have been elected to the board of regents of the American College of Hospital Administrators, the college announced last month.

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NEWS...

Members of Kings County Medical Society Vote to Change Code of Ethics

NEW YORK.—Members of the Kings County Medical Society, New York, have voted four to one to recommend changes in the physicians' code of ethics of the New York State Medical Society.

The resolutions approved by the county medical society are: (a) No prepayment medical care program

could advertise for subscribers; (b) treatment of patients by hospitals and other clinics would be restricted to patients who are "public charges"; (c) hospitals or clinics offering services to patients would be disapproved because they do not offer an "unrestricted freedom of the patient" to select his own physicians; (d) the proration of fees among two or more doctors would be approved if fees were commensurate with services rendered, and other conditions were met.

Dr. George Baehr, president and medical director of the Health Insurance Plan of Greater New York, said the proposed change in ethics would destroy "all nonprofit health insurance plans." He warned that the recommendations of the Kings County society, besides having an adverse effect on health insurance plans, would "revert medical and teaching hospitals to conditions of 100 years ago."

The society recommended that when an insurance company pays a fixed indemnity for the treatment of an ailment, and two or more physicians join in the medical care, the fee shall be shared by the physicians in proportion to the care rendered by each, which is not now the practice, it was pointed out.

At an executive council hearing of the society, Dr. Karl Pickard, administrator of H.I.P.'s Central Medical Group of Brooklyn, condemned the recommendation as "legalized fee-splitting." However, the four recommendations were approved by the executive council last month after a vote of the membership. About one-fourth of the society's 4500 members participated in the voting, it was reported.

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Commission Releases List of 3265 Approved Hospitals

CHICAGO.—The first list of approved hospitals released by the new Joint Commission on Hospital Accreditation included 3265 institutions, compared to 3352 hospitals on last year's approval list of the American College of Surgeons.

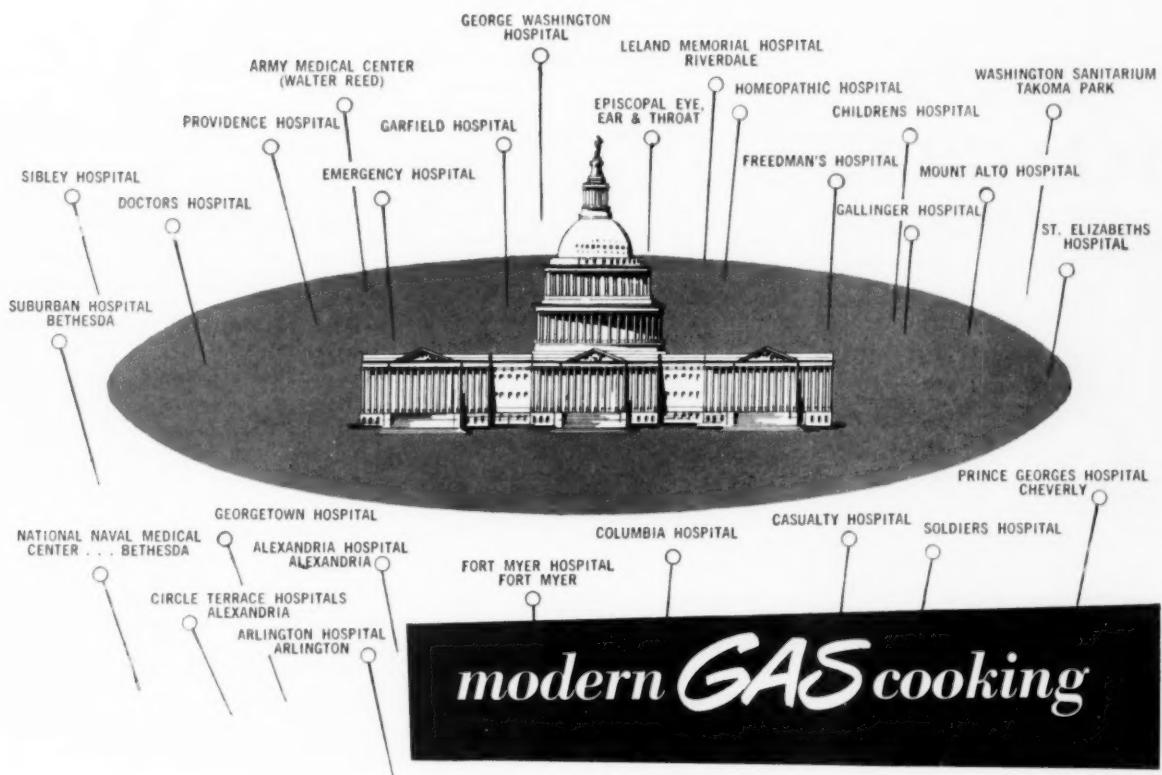
Of this year's total, 2834 hospitals are fully accredited; the remaining 431 received provisional accreditation, Dr. Edwin L. Crosby, commission director, explained.

Dr. Dent New President of National Health Council

NEW YORK.—Albert W. Dent, president of Dillard University, New Orleans, was elected president of the National Health Council last June at the regular meeting of the board of directors. Chosen president-elect at the council's annual meeting in March, Dr. Dent completes the unexpired term of his predecessor, Dr. Robin C. Buerki, who resigned.

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NEWS...

Patient Gets Only Fourth of Nurse's Time, Study Shows

NEW YORK.—Only one-fourth of a nurse's time is spent in caring for her patient, Esther Thompson, director of the division of nursing education at the University of Rochester, told nearly 600 representatives of nursing schools and public health agencies here.

Miss Thompson's statements were based on a study of functions performed by 578 nurses in 10 New York City hospitals and two upstate New York hospitals. She spoke at the opening session of a two-day conference on the curriculum given by the New York State League for Nursing and the New York State Department of Education.

The rest of the working day, she said, is filled with indirect care of the patient, clerical activities, attention to equipment and supplies, dietary needs of the patient, other nonprofessional functions, and teaching. Other findings of the study emphasized the need for a more dynamic program of nurse training, including the elimination of repetitious courses and an expanded development of technical skills and judgment keyed to the problems posed by patients.

Too much time is lost before student nurses are allowed to assist patients, Mrs. Alameda MacCambridge, educational director of the Lenox Hill Hospital School of Nursing, said in reviewing what the school had found in training its students. She also suggested that students could help plan

their own courses of study by having the nursing schools arrange conferences between students and the faculty.

Capt. Alice Taylor of Walter Reed Army Hospital, Washington, D.C., explained that a situational approach, where students act like patients, provides a more vivid learning experience for the practical nurses trained there.

Mary Shields, assistant director of the department of diploma and associate degree programs for the National League for Nursing, discussed the league's project. Information is compiled on abilities needed in nursing, she said; the project also seeks data on the degrees of skill acquired by nursing graduates of a four-year college course, a three-year hospital school course, and a one-year practical nurse course.

Dr. Samuel McLaughlin of the New York University School of Education discussed the importance of helping a student nurse develop a feeling of security through a well planned curriculum and friendly guidance.

Dr. Wilinsky Honored

BOSTON.—Dr. Charles F. Wilinsky, who retired last month as executive director of Beth Israel Hospital here, has received the Lemuel Shattuck Award of the Massachusetts Public Health Association "for his outstanding contributions to the advancement of public health in Massachusetts."

UNIVERSITY OF PITTSBURGH HOSPITAL ADMINISTRATION GRADUATES



First row, left to right: Niles Titler, Edward Davis, Donald Valentine, David Moore. Second row: Albert Mayer, Leonard Zimet, Dr. James A. Crabtree; W. J. McNerney, assistant professor; Selvin Lewis, Dr. Glidden Brooks, professor; Dr. Joseph Campbell, Rocco Mattica.

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NEWS...

Specialists' Arrangements Reported in 44 Hospitals

LANSING, MICH.—Arrangements with specialists in 44 hospitals were summarized in a survey report released by the Michigan Hospital Association in its bulletin here.

The survey was conducted by Don Carner, administrator of the Methodist Hospital, Fort Wayne, Ind., among members of the University of Chicago Correspondence Club, it was explained.

Of the 44 hospitals studied in the survey, 28 or 63.6 per cent, have a "percentage of income" arrangement with radiologists, it was reported. Sixteen hospitals, or 36.4 per cent, are paying radiologists on a salary basis. None of the hospitals had a lease or rental arrangement with the radiologists, the survey indicated.

Among radiologists, the average full-time compensation on the percentage arrangement was \$28,300 a year. The average salary for full-time radiologists was \$15,000 per year. Part-time radiologists received \$6340 a year on the percentage arrangement, and \$11,300 a year in salaries.

Thirty-nine hospitals reported on their arrangements with pathologists. Fourteen of these, or 35.9 per cent, were on a percentage arrangement, and 25, or 64.1 per cent, were on salaries. Average full-time compensation for pathologists on the percentage arrangement was \$19,900 a year; full-time salaries paid to pathologists averaged \$16,500 a year. On part time, pathologists received an average of \$15,000 a year on the percentage arrangement, and \$3100 a year in salary.

"There is no clear-cut pattern for the percentage arrangement," the report of the survey in the *Michigan Hospital Association Bulletin* stated. "As many contracts are based on a percentage of the gross income as are based on a percentage of the net income of the department. The percentage averages 42.6 when net figures are used; when gross figures are used, the average is 34.2 per cent."

Comparing results of the survey with those obtained in a similar survey of Michigan hospitals conducted in 1950, the bulletin reported: "As of 1950, a higher percentage of Michigan professional service contracts were on a commission basis than was reported by members of the University of Chicago Correspondence Club." The latter survey was made in August 1952.

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NEWS. . .

Hospital's Corridors Hung With Paintings

NEW YORK CITY.—From the income of an anonymous gift for the purchase of works of art, the New York Hospital budgets the sum of \$10,000 annually and has collected 800 paintings during the last seven years, according to Willard S. Simpkins, chairman of the hospital's art committee.

The hospital's 23 floors and 300 rooms provide 30 miles of corridor wall space.

Mr. Simpkins said he became interested in art in hospitals as a result of spending a great deal of time in 14 hospitals as a patient after World War I. "I nearly went crazy," he said, discovering that although hospitals were efficient in medical matters they were not always attentive to "the needs of the inner man." He decided to give some attention to this at New York Hospital.

The basic idea behind the paintings is to get patients' minds off themselves and get their imaginations going.

There is considerable variance in the style of paintings displayed in the hospital—some are entirely naturalistic, others are of the modern trend, showing abstraction or primitivism. The hospital's most abstract works, mobiles, were hung in the children's clinics.

Large R.F.C. Loan to Hospital on Long Island

MANHASSET, N.Y.—A loan of \$750,000 has been granted the North Shore Hospital here by the Reconstruction Finance Corporation, the hospital announced last month. This was reported as the first of its kind to be granted by the agency under the provisions of the Civil Defense Act of 1951. Since the hospital is located on the fringe of New York's "bombing area" and may be required to treat large numbers of injured persons in the event of an attack, the urgent need for its completion was recognized by the hospital's trustees, who applied for the mortgage loan a year ago, it was reported.

A fund raising campaign will be continued in an effort to raise the remainder of the \$4,000,000 needed to complete the hospital's financing.

West Virginia Hospitals Reject Cost Principle in Third Party Payments

CHARLESTON, W.VA.—In a bulletin to member hospitals released here last month, the West Virginia Hospital Association reported adoption of a resolution "discouraging all members from submitting the federal formula of reimbursable costs and/or other cost statements to any agency, individual, government, or private organization requesting the same."

Explaining the association's position, William R. Huff, executive secretary, said it was felt that the cost principle does not provide a true picture of hospital costs because "it fails to recognize some items of expenditure which are actual costs of operation."

The cost concept varies with individuals, Mr. Huff explained; therefore statements do not reflect the existing situation in many hospitals.

"There is a general feeling that a departure from the cost system of hospital billing will tend to lower the retail sale price of hospitalization to the public over a period of time. This contention is given added support when it is shown that hospitals lose money on the cost principle, making it inevitable that persons paying private hospital billing are called upon to provide the difference in price."

The Hospital Statement of Reimbursable Costs referred to in the association's resolution was developed with the assistance of the American Hospital Association and has been widely used by third party payers for hospital service, including governmental agencies, insurance companies, Blue Cross and private welfare groups. "By its own resolution, the West Virginia Hospital Association has placed hospital charges in the same category as commodity prices which are determined by bargaining in a market place," said a representative of one agency, following release of the association's statement. "It would appear that the institutional members of the West Virginia Hospital Association do not accept the responsibility inherent in the privileged status of hospitals in the community, although they enjoy federal and state subsidies, a privileged monopoly, freedom from fiscal control exercised over public utilities and schools, tax exemption and special tax consideration."



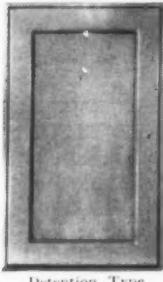
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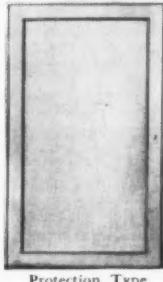
You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

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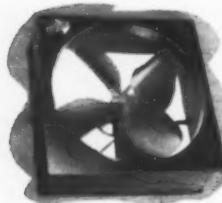
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NEWS...

Budget Cuts Cause Three Hospitals to Close

WASHINGTON, D.C.—An 18.9 per cent cut in the budget of the Public Health Service for fiscal 1954, amounting to \$51,228,000, has forced the closing of three hospitals and has reduced funds for medical research and state aid, according to disclosures made in testimony by Department of Health, Welfare and Education officials and P.H.S. officers before a House appropriations subcommittee recently.

When a project under way in Pittsburgh has been completed, the reductions will also bring to an end the Public Health Service's mass x-ray program for tuberculosis detection.

The department is considering closing hospitals at Cleveland, Savannah, Ga., and Fort Stanton, N.M., Roy L. Harlow, finance officer, said.

Smoking Ban Tightened in New York Hospitals

NEW YORK.—A ban against smoking in municipal and proprietary hospitals has been tightened, Dr. Marcus D. Kogel, commissioner of hospitals, announced last month. He stated that smoking has been made a punishable misdemeanor under the city hospital code.

Dr. Kogel explained that the frequent presence of highly flammable or explosive items such as ether and oxygen make smoking or any open flame a danger to life and property. Staff members and patients will be permitted to smoke in specified safe areas, he added.

Teaching Affiliation With Kessler Institute

WEST ORANGE, N.J.—The Kessler Institute for Rehabilitation here will affiliate for teaching purposes with New York Medical College and Flower and Fifth Avenue Hospital in New York City, it was announced last month.

Dr. Jerome Tobis, director of the department of physical medicine and rehabilitation at New York Medical College, is a member of the consulting medical staff of the Kessler Institute for Rehabilitation; Dr. Henry H. Kessler, medical director of the institute, is a clinical professor of rehabilitation at New York Medical College.

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Vol. 81, No. 2, August 1953



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See Vollrath booth No. 154 . . . August 31-September 3
American Hospital Association Convention
Civic Auditorium, San Francisco, Calif.

NEWS...

Times Study Finds Many Hospitals in the Red

NEW YORK.—Rising costs of operation and maintenance are placing heavy financial burdens on voluntary, nonprofit hospitals here. Despite scattered improvement in recent years, many such institutions are still running in the red, with no immediate solution in sight, a *New York Times* writer told the public in a recent series of articles.

The prospects for new construction

to replace obsolete buildings is in some instances becoming progressively worse, the *Times'* study of hospital problems found.

New York City has never had a unified or federated capital fund raising drive involving all its voluntary hospitals, the newspaper pointed out, although the United Hospital Fund has functioned successfully in collecting money for the operational needs of its member institutions for 73 years. The *Times* points out that some offi-

cials think unified capital fund raising would be unsuccessful since many of the voluntary hospitals are operated directly or indirectly under sectarian or quasi-sectarian sponsorship.

Polio Cases Up 2 per Cent Over Same 1952 Period

WASHINGTON, D.C.—The Public Health Service announced last month that 949 new polio cases were reported in a single week, compared with 1004 in a corresponding period last year.

Since the start of the "polio season" last spring, 4112 cases have been reported. This is a gain of 2 per cent over the total for the comparable 1952 period. However, the service pointed out, a "high proportion of this year's cases are nonparalytic."

The following nine states had sizable one-week increases: North Carolina, 76 cases; Ohio, 66; Illinois, 57; Virginia, 39; Pennsylvania, 15, and Connecticut and New Jersey, 14 each.

Forty-seven of the new cases in North Carolina were in Caldwell and Catawba counties, where the children were inoculated with gamma globulin to cut down the paralyzing effects of the disease. No official reports were received from New York and Alabama, where gamma globulin has been given in mass immunization tests.

School Pupils Are Given Basic Facts on Hospitals

TORONTO, ONT.—Hospital information has been taught in the high school classrooms in Ontario this year. Some 75,000 students in Grades 9 and 10 have been hearing basic facts about hospital service, careers and finances, reports Arthur J. Swanson, executive secretary-treasurer of the Ontario Hospital Association.

The hospital association first won the cooperation of L. S. Beattie, superintendent of secondary education for Ontario, in making a general presentation of basic facts about hospitals to students. The project is not compulsory but has been recommended to high school principals by Mr. Beattie. The association prepared a reference booklet for teachers and a leaflet for teachers.

After this year the plan is to present this material in Grades 7 and 8, which in this country are in the primary schools.

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C. welchi	2 hours	2 hours	1½ hours	1½ hours
B. anatum	1½ hours	1½ hours	1½ hours	1½ hours

VEGETATIVE BACTERIA	5 min.		15 sec.	
	E. coli	3 min.	15 sec.	15 sec.
Staph. aureus	5 min.	15 sec.	15 sec.	15 sec.
Strep. hemolyticus	2 min.	15 sec.	15 sec.	15 sec.



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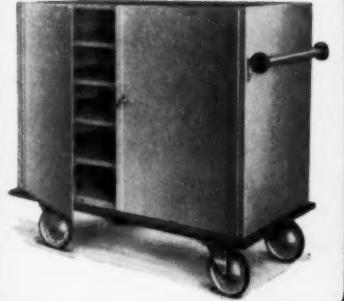
COLSON Model 4935 Inhalator for treating respiratory ailments. Visible water supply, high and low speed, control to prevent overheating if water supply is exhausted.



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NEWS...

New York State Gets Plan to End Discrimination in Medical Schools

ALBANY, N.Y.—A program to eliminate alleged discrimination in admissions to medical schools in New York State was recommended here last month in a report by the state board of regents.

The recommendations resulted from a study of medical school admissions practices conducted by a committee headed by Dr. Howard E. Wilson, executive assistant of the Carnegie Endowment for International Peace.

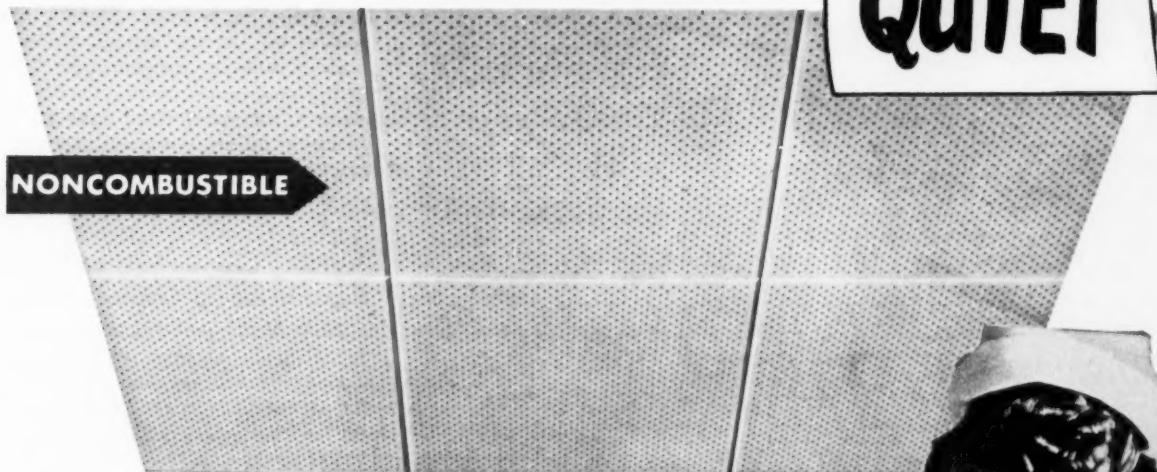
Based on statistical samples of applications and admissions at the state's nine medical schools in 1950 and 1952, the survey indicated there was no discrimination among applicants as to race or sex. However, the report said, a larger proportion of Protestant and Catholic than of Jewish applicants had been accepted in both years. "Top ranking Protestant and Catholic students are more certain to be admitted than are top ranking Jewish students," it stated. "At the other end of the scholastic scale, low rating Jewish students are virtually excluded, while occasional low rating Protestant and Catholic applicants are admitted."

Factors identified in the survey as important in the selection of students included "national origin and recency of identification with American life and culture." The combination of cultural traits commonly described as "personality" is of considerable consequence in student selection, the committee found, but measurement of personality is "so loose and vague at present that illegal discrimination against groups as a whole cannot be proved and cannot be disproved," the committee stated.

Recommendations of the committee would establish exploratory studies in this field under the direction of the state department of education. The committee also recommended that the state board of regents initiate "basic studies on the nature of personality characteristics and their relation to the professions."

It recommends that each medical school "formally and publicly declare its position respecting discrimination as defined in the Education Practices Act [passed in 1948, forbidding discrimination in admissions to educational institutions on the bases of race, religion, color or national origin] and

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coustic panels may be applied with new construction or over existing ceilings and are easily removed for access to services.

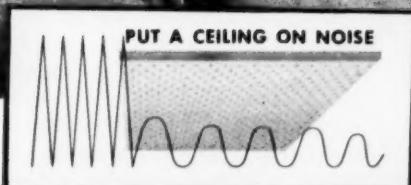
Other Johns-Manville Acoustical Ceilings include perforated *Transite** Acoustical Panels, recommended for those areas subject to excessive moisture; *Permacoustic*, a textured non-combustible tile; and *Fibretone*, a budget-priced drilled fibreboard unit.

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NEWS...

formulate as explicitly, precisely and comprehensively as possible" its criteria for admission. The medical schools should also improve their handling of applications, it was stated. Undergraduate colleges are urged to develop strengthened guidance of premedical students and to consider having an authorized faculty committee make recommendations on applicants to medical schools.

Nursing League Sets up New Committee on Accreditation

NEW YORK.—An executive committee on accreditation policies to replace the former advisory committee on accreditation has been set up by the National League for Nursing's Division of Nursing Education, it was announced at League headquarters here last month. Membership of the committee will include representatives of the National League for Nursing, the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association, the American Medical Association, the American Public Health Association, regional accrediting agencies in representative general education, higher education, and the public, the announcement said.

The committee's functions will include receiving reports from boards of review, considering problems and recommendations identified by boards of review, formulating procedures and policies, evaluating progress in relation to objectives and policies of the National League for Nursing Accrediting Service, it was explained.

Clinic Heads Organize Merger Minneapolis

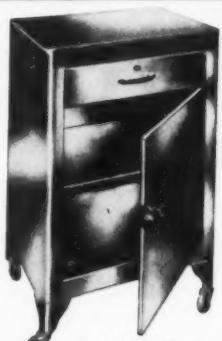
MINNEAPOLIS.—Merger of St. Andrews Hospital with St. Barnabas Hospital has been announced here by Dr. Karl S. Klicka, director of St. Barnabas. This action, which became effective February 1, has increased the bed complement of St. Barnabas to 270 beds and 45 bassinets. Dr. Klicka will be director of both hospitals.

Telmer O. Peterson, formerly of James A. Hamilton Associates, has been named administrator of St. Andrews, and Boyd A. Sanderson remains assistant director of St. Barnabas Hospital, a position he has held since July 1, 1952.

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Instrument Stands
Instrument Tables
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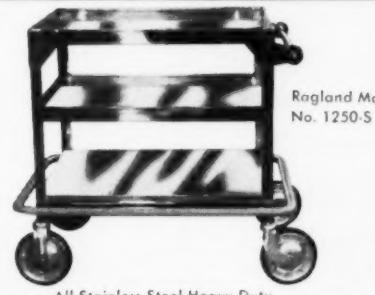


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ABOUT PEOPLE

(Continued From Page 88)

Dr. Louis F. Verdel is now manager of the V.A. Hospital nearing completion in Salisbury, N.C. Dr. Verdel had been manager of the V.A. Hospital in Northport, L.I., N.Y., since 1944.

Dr. Edward H. Mandell, assistant chief of professional services at the V.A. Hospital in Minneapolis, has been appointed manager of the V.A. Hospital in Saginaw, Mich., succeeding Dr.

Morley B. Beckett. Dr. Beckett has been transferred to the new V.A. Hospital in Ann Arbor, Mich.

Elizabeth Yearly is now business manager of Jones County Community Hospital, Laurel, Miss. Miss Yearly had been with Lutheran Hospital, Vicksburg, Miss., before going to Laurel.

Dr. Myron D. Miller has been named successor to the late **Dr. William W. Nesbit**, formerly medical officer in charge of the U.S. Public Health Service Hospital, Seattle. Formerly, Dr. Miller was assistant chief of the division of hospitals, Public Health Service,

Washington, D.C. He has also been superintendent and medical director of Benjamin Franklin Hospital, Columbus, Ohio.

Dr. Wilbur G. Jenkins has been appointed superintendent of Osawatomie State Hospital, Osawatomie, Kan., effective June 1, succeeding **Dr. Milton C. Anderson**. Dr. Jenkins had been superintendent of the Abilene State Hospital, Abilene, Tex., for the last two years.

Loren Hesla and **Stanley Allen** have joined the administrative staff of Presbyterian Hospital Center, Albuquerque, N.M. Mr. Hesla is a graduate of Southern Methodist University and the University of Minnesota course in hospital administration; his administrative residency was served at Hillcrest Medical Center, Tulsa, Okla. Mr. Allen was administrative resident at Swedish Hospital, Minneapolis, did his undergraduate work at the University of Minnesota, and is a graduate of the University of Minnesota course in hospital administration.

Dr. Harold Marks has been replaced as superintendent of San Joaquin General Hospital, French Camp, Calif., by **Dr. Louis Barber**, director of the Bret Harte Sanatorium, Murphys, Calif.

Benny Carlisle has been named administrator of Washington County Hospital, Fayetteville, Ark.

Arthur G. Hennings, assistant superintendent of Butterworth Hospital, Grand Rapids, Mich., has resigned effective September 1. He has accepted a position with the firm of James A. Hamilton and Associates of Minneapolis, and will also be on the faculty of the hospital administration course at the University of Minnesota, where he received his master's degree in hospital administration. Mr. Hennings holds membership in the American Hospital Association and the American College of Hospital Administrators.

Dr. M. Herbert Fineberg has been named manager of the Veterans Administration Hospital at Wilkes-Barre, Pa. Prior to his new appointment, Dr. Fineberg had been at the V.A. Hospital in Dwight, Ill.

James Putnam became business manager of Washington County General Hospital, Greenville, Miss., on June 29.

A. C. Seawell, for the last six years administrator of Pottstown Hospital, Pottstown, Pa., will become administrator of Butler County Memorial Hospital, Butler, Pa., October 1. A former president of the Texas Hospital Association, Mr. Seawell is now a trustee of the



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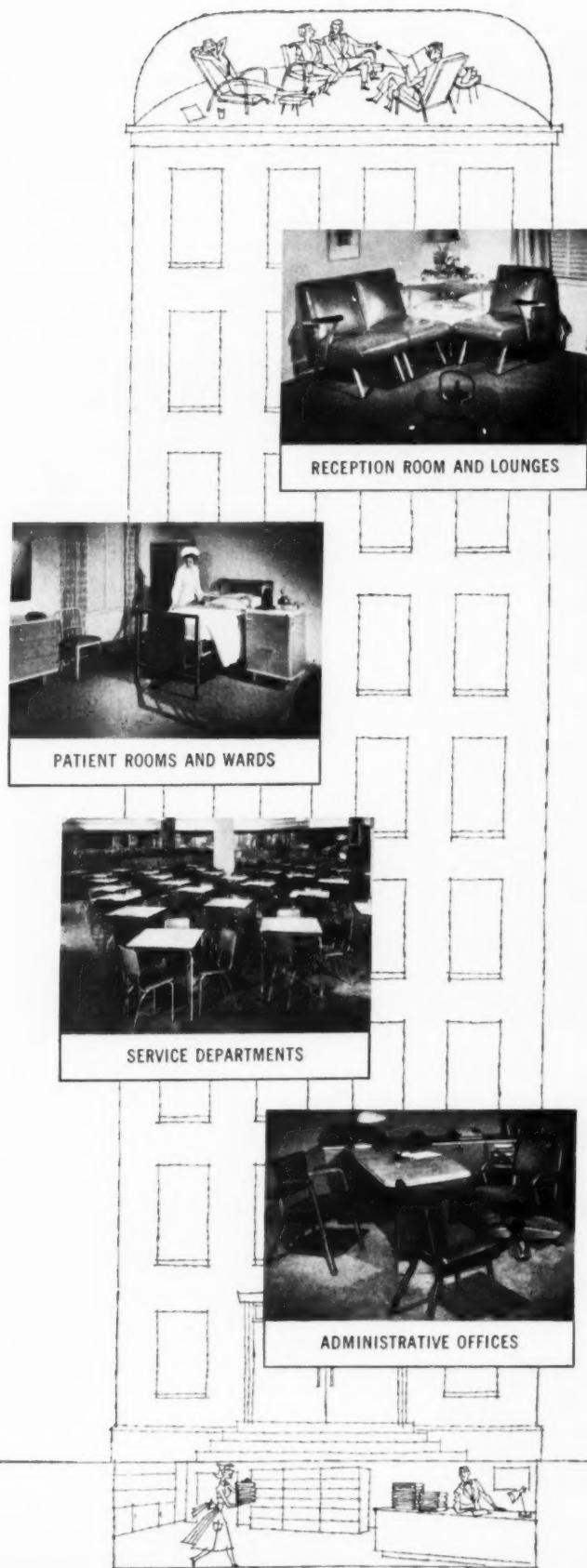
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Hospital Association of Pennsylvania and for the last three years has been chairman of the council on public relations. He is a past president of the Eastern Regional Hospital Association and a fellow of the American College of Hospital Administrators.

Jerome T. Bieter assumed his duties as administrator of Uniontown Hospital, Uniontown, Pa., on June 1, succeeding **Arthur K. Besley**. He had been assistant director of Rhode Island Hospital, Providence. Mr. Bieter has a master's degree in hospital administration from the University of Minnesota.

Kathryn Lawler, assistant superintendent of Jersey Shore General Hospital, Point Pleasant, N.J., has been named superintendent of the hospital, succeeding **Dorothy Nagle**. Prior to going to Point Pleasant, Miss Lawler had been at Doctor's Hospital, Philadelphia.

William P. Ryan Jr. has accepted the position of administrative assistant at Western Pennsylvania Hospital, Pittsburgh. Mr. Ryan had been assistant administrator at Meriden Hospital, Meriden, Conn., until his recent appointment. After receiving his mas-

ter's degree in hospital administration from Columbia University, he served an administrative residency at Hartford Hospital, Hartford, Conn.

John B. Richardson has been named administrator of the Allegheny Valley Hospital, Tarentum, Pa. He succeeded **LeRoy C. Schaeffer**, who had been administrator for nine years. Until his recent appointment, Mr. Richardson was administrator of the Armstrong County Memorial Hospital at Kittanning, Pa. He took over his new duties July 1.

Dr. John L. Smalldon has announced that he will resign as superintendent of the New Hampshire State Hospital, Concord, effective September 1.

Fred C. Klein, administrative assistant at Memorial Hospital of Sweetwater County, Rock Springs, Wyo., has resigned to accept a position as administrator of Good Samaritan Hospital, Sterling, Colo.

R. O. Daughety is the new administrator of Tompkins County Memorial Hospital, Ithaca, N.Y. Formerly, he was administrator of the University Hospital at Augusta, Ga. Among the organizations of which he is a member are: the American College of Hospital Administrators, the American Hospital Association, the Texas Hospital Association, and the Houston Hospital Council.

Sister Mary Rose McPhee, assistant director of St. Vincent's school of psychiatric nursing, St. Vincent's Hospital, St. Louis, has been appointed administrator of Mary's Help Hospital, San Francisco. Sister Mary Rose headed the psychiatric nursing department at St. Joseph's Hospital, Chicago, before going to St. Louis.

Dr. David J. Zaugg has been appointed medical officer of the U.S. Public Health Service Hospital, Chicago. Dr. Zaugg took over his new duties July 1, after leaving the U.S. Public Health Service Outpatient Clinic in New York City, where he had been medical officer.

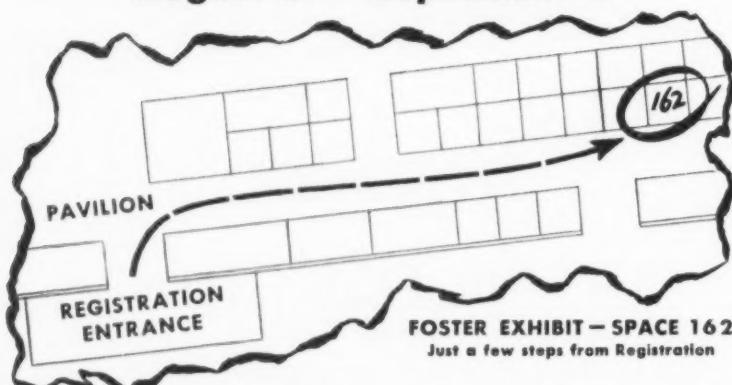
Dr. Stewart T. Ginsberg has been appointed manager of the new neuropsychiatric hospital which is nearing completion at Pittsburgh. Dr. Ginsberg had been chief of professional services at the V.A. Hospital in Marion, Ind.

Stanley A. Read has joined the administrative staff of Laconia Hospital, Laconia, N.H. His administrative residency was served under **Donald Rosenberger** at the Maine General Hospital, Portland, Me.; he received his master's

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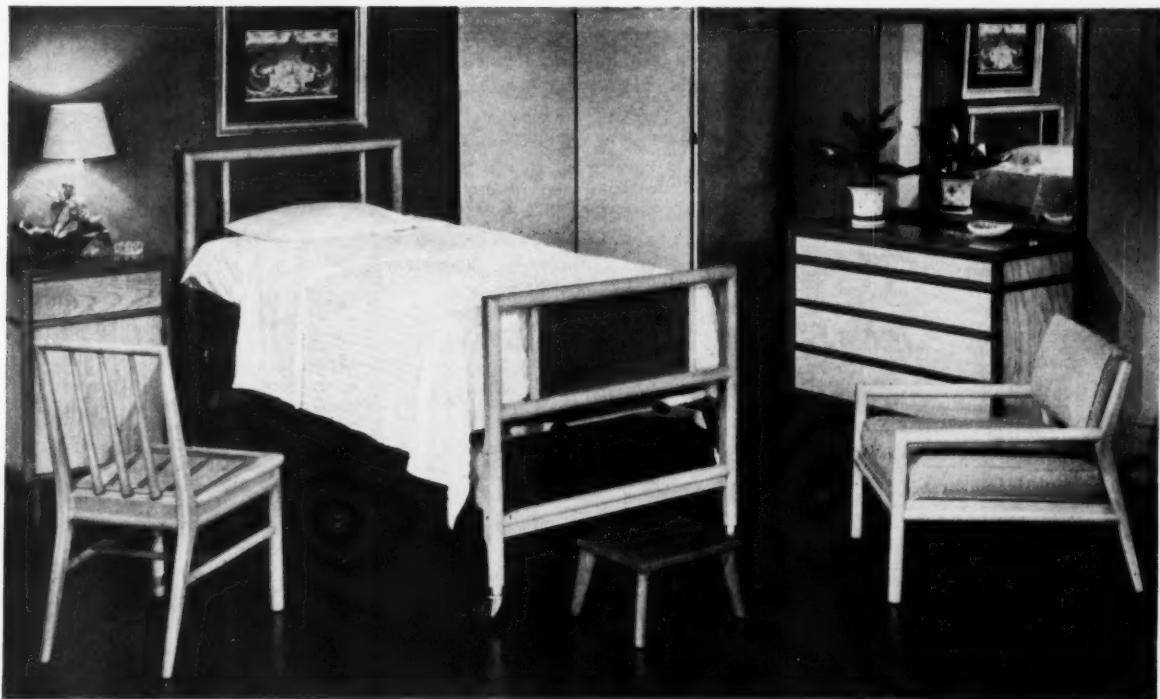
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degree in hospital administration from Northwestern University.

Dr. John G. Hood, formerly manager of the V.A. Hospital in Richmond, Va., is the new manager of the V.A. Hospital in the Bronx, New York City.

Frank L. Mowry, administrator of Sullivan County Memorial Hospital, Milan, Mo., has resigned effective September 1.

Dr. Louis M. Hohman, chief of professional services at the V.A. Hospital, Indianapolis, since July 1948, has been appointed manager of the V.A. Hospital at Clarksburg, W. Va.

Gordon W. Epperson, former personnel and public relations director at Hillcrest Memorial Hospital, Waco, Tex., has been named assistant administrator of the Baptist Hospital, Beaumont, Tex.

Lilian M. Thompson has been appointed administrator of Children's Orthopedic Hospital, Seattle, where she has served as superintendent since 1941. The position of administrator was created with the opening in April of the institution's new hospital.

Arthur L. McElmurry has been named to the newly created position of administrator of the University of Oklahoma Hospital, Oklahoma City. Previously Mr. McElmurry was business manager of the hospital.

Richard N. Kerst has been appointed assistant vice president of Presbyterian Hospital, New York City. His new duties will include special assignments affecting all divisions of the medical center. Mr. Kerst has been controller of the hospital since 1948.

Stephen Taras has been appointed assistant director of the Jewish Hospital of Brooklyn, N.Y. Mr. Taras was formerly administrator of Chadron Municipal Hospital, Chadron, Neb., and received his degree in hospital administration from Teachers College, Columbia University.

Richard G. Schreiber is now administrator of the Ottumwa Hospital, Ottumwa, Iowa. He was formerly superintendent of the Edgewater Hospital, Chicago.

Dr. Peter A. Peffer, manager of the V.A. Hospital at Perry Point, Md., has been appointed manager of the new V.A. Hospital for neuropsychiatric patients now being completed at Brockton, Mass.

William W. Lamont has been named administrator of Franklin Hospital, Benton, Ill. Prior to accepting this new appointment, he had been manager of Union Hospital, West Frankfort, Ill.

John F. Berry, assistant superintend-

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ent of Springfield Hospital, Springfield, Mass., has resigned to accept the superintendence of Soldiers' Home, Holyoke, Mass.

Robert E. Sleight, assistant director of the University of Virginia Hospital, Charlottesville, resigned to become assistant superintendent of the New England Center Hospital, Boston. He took over his new duties on June 15.

Robert F. Tuveson has been named assistant superintendent and purchasing agent of the Middlesex Memorial Hospital, Middletown, Conn.

N. J. Karabach, administrative resi-

dent at Springfield Hospital, Springfield, Mass., will begin his duties in September as superintendent at the Prospect Heights Hospital, Brooklyn, N.Y.

Thomas P. Dailey has been appointed assistant administrator of the Staten Island Hospital, Staten Island, N.Y. He completed his administrative residency at the hospital in June; he attended the course in hospital administration at Columbia University. Mr. Dailey is a member of the American Hospital Association.

Philip J. Olin has been named asso-

ciate administrator of the Memorial Hospital Association of Kentucky, to be erected at Beckley, W.Va. Mr. Olin, formerly personnel officer for the University Hospital, Ann Arbor, Mich., will be in charge of personnel affairs.

Department Heads

Martha C. George



Martha C. George

George has joined the nursing administrative staff of Cleveland Clinic Hospital, Cleveland, as supervisor of non-professional nursing personnel. Earlier this year, she received a bachelor of science degree in ward management and teaching from Western Reserve University.

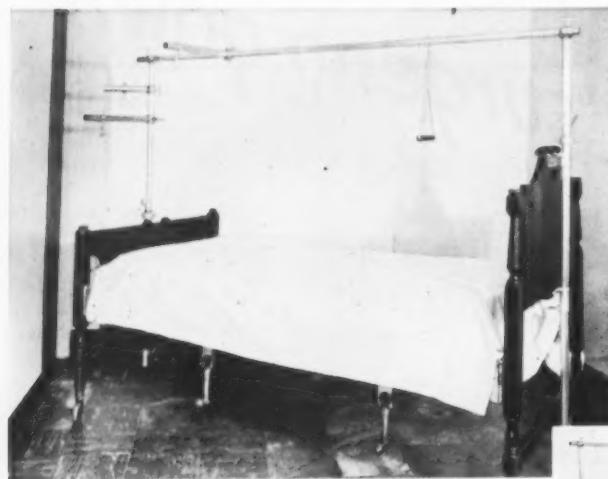
Mary Louise Clippinger has been appointed chief dietitian of Aultman Hospital, Canton, Ohio. Miss Clippinger was formerly assistant director of patient service at New York Hospital, New York City. She succeeds **Mrs. Reva Mills**, who resigned because of ill health. Miss Clippinger is a member of the American Dietetic Association and the Greater New York Dietetic Association.

Ava S. Dilworth and **Josephine I. O'Connor** have been named assistants to the chief of the nursing department at the Clinical Center, National Institutes of Health, Bethesda, Md. **Janet Fitzwater** was appointed chief of the surgery nursing service in the nursing department of the Center, and **Jane Wilcox** was named chief of the heart nursing service.

Dr. Elizabeth Kerr Porter, head of the advanced professional program at Western Reserve University's Frances Payne Bolton School of Nursing, and president of the American Nurses Association, has been named dean of the university's nursing school. Dr. Porter's appointment became effective August 1. She succeeded **Dr. Helen L. Bunge**, who resigned to become executive officer of the new institute for research in nursing at Teachers College, Columbia University. Before going to Western Reserve in 1949, Dr. Porter was professor of nursing education and coordinator of the advanced clinical nursing program at the University of Pennsylvania.

Miscellaneous

Dr. Francis M. Forster has been named dean of the Georgetown University School of Medicine, effective



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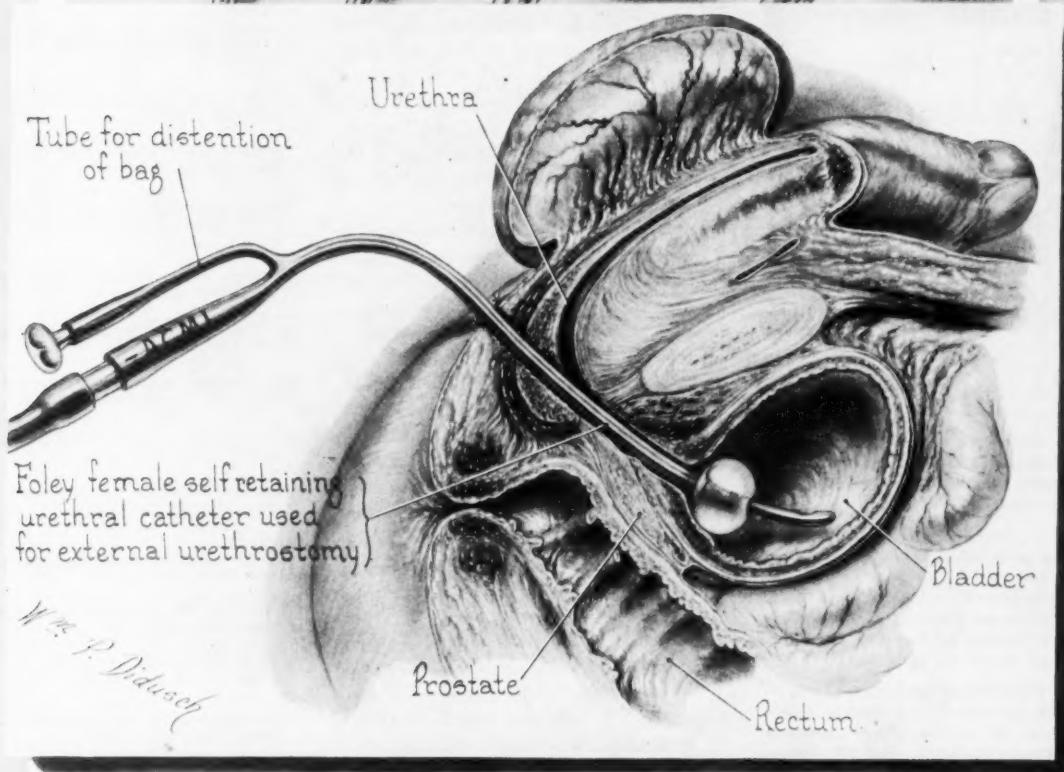
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July 1, succeeding the Rev. Paul A. McNally, regent and dean since 1947. Dr. Forster has been at Georgetown for three years, as professor of neurology and head of the department of neurology. He is chairman of the section on mental and nervous diseases of the American Medical Association and vice president of the American Academy of Neurology.

Dr. Edward L. Turner, dean of the school of medicine, University of Washington, Seattle, has been named secretary of the A.M.A.'s Council on Medical Education and Hospitals. He will take over October 1, succeeding Dr. Donald G. Anderson, who is dean of the University of Rochester college of medicine. Dr. Anderson has been secretary of the council since 1947. In addition to his position as dean, Dr. Turner is also chairman of the division of health and sciences at the university, which includes the schools of medicine, dentistry, nursing and pharmacy. His M.D. was received from the University of Pennsylvania in 1928; he had also studied at the University of Chicago. From 1938 to 1944, Dr. Turner served as president of Meharry Medical College, Nashville.

Dr. Phillip Bard is the new dean of the Johns Hopkins University School of Medicine. He has been on the faculty since 1933 and, while serving in this new position, he will continue to teach physiology.

Sister Mary Susanne Smity, S.S.M., a member of the faculty since 1939, has been appointed dean of the Saint Louis University School of Nursing. Sister Susanne succeeds Sister Mary Geraldine Kulleck, S.S.M., dean since 1945, who has become superior of the Firmin Desloge Hospital of the university.

Col. Kermie H. Gates, MC USA, is now deputy post commander of Walter Reed Army Medical Center, Washington, D.C. He succeeds Col. Joseph U. Weaver, MC USA. For the last three years, Col. Gates has been chief medical officer at Fort Jackson, S.C.

Deaths

Howard L. Burrell, general counsel of the California Hospital Association, died of a heart attack late in May.

J. O. Sexton, former administrator of the Good Samaritan Hospital, Phoenix, Ariz., died June 19 of a heart attack. After his retirement about five years ago, he was made president of the hospital's board. He was a former president of the Arizona Hospital Association.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Palace Hotel, San Francisco, Oct. 5-9.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, 19th Annual Meeting, San Francisco, Aug. 29-31; Institute for Hospital Administrators, Chicago, Sept. 14-24; Southwestern Institute for Hospital Administrators, Houston, Tex., Nov. 16-20; Human Relations Conference, Montreal Quebec, Nov. 23, 24; Human Relations Conference, Kansas City Mo., Dec. 7, 8.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, San Francisco, Aug. 31—Sept. 3.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Los Angeles, Oct. 18-21.

CALIFORNIA HOSPITAL ASSOCIATION, Hotel Mar Monte, Santa Barbara, Oct. 29, 30.

COLORADO HOSPITAL ASSOCIATION, Antlers Hotel, Colorado Springs, Nov. 19, 20.

FLORIDA HOSPITAL ASSOCIATION, Miami Beach, Dec. 1, 2.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 3, 4.

INSTITUTE ON DIETARY DEPARTMENT ADMINISTRATION, Park Sheraton Hotel, New York City, Oct. 26-30.

INSTITUTE ON HOUSEKEEPING, Somerset Hotel, Boston, Nov. 16-20.

INSTITUTE ON LAUNDRY, Park Sheraton Hotel, New York City, Nov. 9-13.

INSTITUTE ON NURSING SERVICE ADMINISTRATION, St. Charles Hotel, New Orleans, Dec. 7-11.

INSTITUTE ON PHARMACY, Loyola University, Los Angeles, Aug. 24-28.

INSTITUTE ON PURCHASING, Penn Sheraton Hotel, Philadelphia, Oct. 19-23.

INSTITUTE ON SUPERVISORY TRAINING, Edgewater Beach Hotel, Chicago, Nov. 2-6.

OREGON ASSOCIATION OF HOSPITALS, Hotel Benton, Corvallis, Oct. 22, 23.

KANSAS HOSPITAL ASSOCIATION, Lassen Hotel, Wichita, Nov. 12, 13.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Lord Baltimore Hotel, Baltimore, Nov. 9, 10.

MISSISSIPPI HOSPITAL ASSOCIATION, Buena Vista, Oct. 14-16.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Nov. 12, 13.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 12, 13.

WASHINGTON HOSPITAL ASSOCIATION, Olympic Hotel, Seattle, Sept. 30-Oct. 1.

1954

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 11-13.

IOWA HOSPITAL ASSOCIATION, Annual Meeting, Savery Hotel, Des Moines, April 21.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, Jan. 26.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 7-9.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.

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WAYNESBORO EDITOR CALLS VICTORY, "WELL-NIGH MIRACULOUS!"

Excerpt from editorial, Waynesboro News-Virginian

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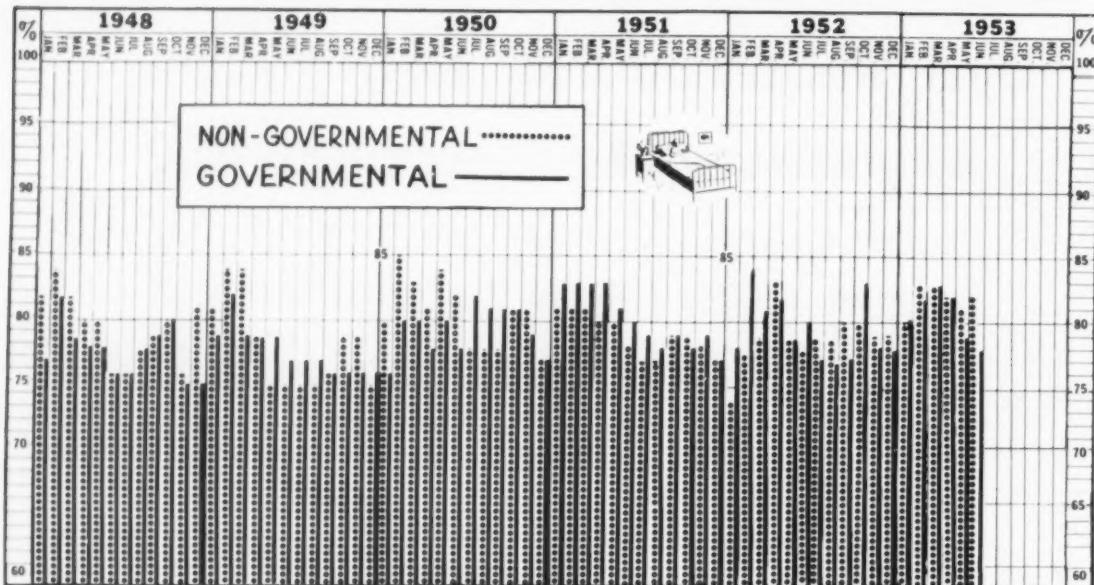
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Hospital Construction Maintains Lead Over 1952



Reports to the Occupancy Chart from governmental hospitals indicate they were 78 per cent occupied during the month of June. This is a 2.9 per cent increase over 1952. Nongovernmental hospitals were filled to 81.9

per cent of their capacity—an increase of 3.8 per cent over the figure of a year ago.

Hospital construction for the two-week period ending July 13 totaled \$18,042,231. This brings the total for

the year to \$357,146,120; by the same time last year construction of new hospitals amounted to \$274,977,822. The current 19 projects include five hospitals, 10 additions, one alteration and three nurses' homes.



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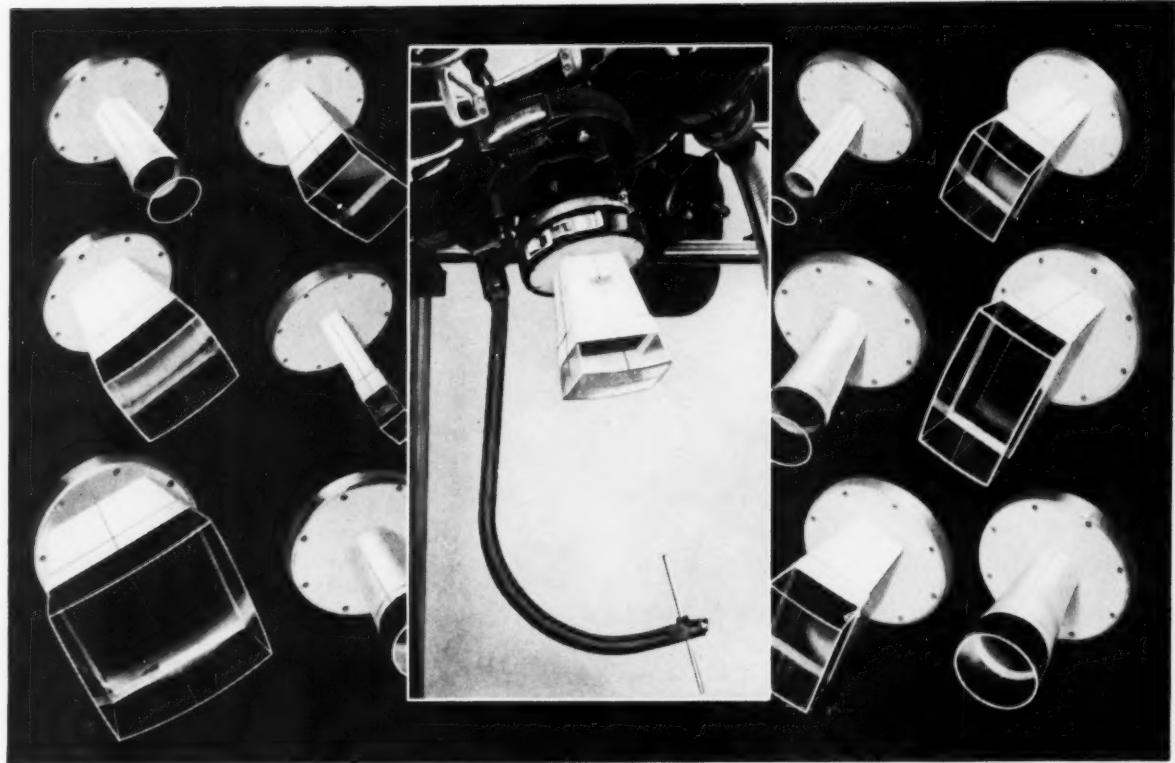
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locked in one section and the assembly locked in place without holding the cone.

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KITCHEN EQUIPMENT

Are you going to remodel your dietary department this summer? Planning a new or expanded kitchen and food service layout? Then you will most certainly need catalog information on food service equipment. Turn to section B in the 30th Edition of Hospital Purchasing File now in your office (A recent survey shows that HPF is in nearly every U.S. hospital—that it is kept in the office of the administrator or purchasing agent). You'll find cooking equipment, food preparation machines, dishwashers, heated carts, dinner ware, garbage disposal equipment, tables and seating for dining rooms—virtually everything you'll need in planning a new dietary department or in making over your present facilities. Call in your dietitian, let her learn how to find needed catalog information first in HPF. And be sure all your other department heads are thoroughly familiar with HPF, too. Be sure you always turn first to HPF when buying information is required. See what the manufacturers (listed at the right) have to offer.

Here are the catalogs in Section B:

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Blodgett Co., Inc., The G. S.
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Cleveland Range Co.
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Foley-Irish Corp.
Gifford-Wood Co.
Gumpert Co., Inc., S.
Hotpoint Inc.
International Silver Co., Hotel Division
Keyes Fibre Sales Corp.
Libbey Glass Division of Owens-Illinois Glass Co.
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Olson Mfg. Co., Inc., Samuel
Pick-Edmunds & Co.
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Prometheus Electric Corp.
Savory Equipment, Inc.
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"First and most important was complete assurance of clean and sterilized linen at all times, processed with just the right amount of bleach, softener, soap and starch. Hoffman washers with their accurate controls and superior washing action gave that assurance.

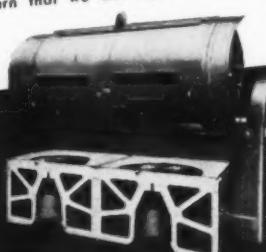
Of almost equal importance were the noise and vibration factors. Site considerations made it mandatory that our laundry be situated in the basement of the building where such considerations might well affect the patients' rest and quiet. The silent chain drive of Hoffman flatwork ironer and the advanced engineering of the extractor offered the ideal solution of these nuisances.

With the ever increasing resistance of the public to rising hospital costs, economy of operation was a prime consideration. Hoffman demonstrated its awareness of the need for such economy, through their engineering assistance in laying out the most efficient machinery setup to meet our particular laundry requirements. This is reflected in our ability to operate our laundry with less personnel than the average hospital of comparable size in the area. The fast-drying action of the Greyhound tumbler, pinpoint control of supplies used, and greater life of linens, due to the easy unloading of the washers, all spell economy of operation.

Twenty-four hours a day, three hundred and sixty-five days a year, the hospital must minister to the needs of its sick and injured. Dependability is the keyword! The experience of these institutions which we visited, with properly installed equipment and maintenance-free operation over long periods of time, and the comforting knowledge of parts and service at a moment's notice (as demonstrated by Hoffman's record throughout World War II) qualified Hoffman as absolutely dependable.

An added bonus not looked for in our original evaluation has been the favorable reaction of applicants for laundry positions when they learn that we are equipped 100% with Hoffman machinery."

In the HOFFMAN Complete Line
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there are Models to Meet the Exact
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ADMINISTRATIVE POSITION or DIRECTOR OF NURSES By registered nurse with several years' experience in both branches; available September first. Reply, MW 12, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR Or assistant administrator; graduate nurse; B.S., Nursing Education; M.P.H., Hospital Administration, 1952; degrees, eastern universities; six years, instructor; six years, director, school of nursing and nursing service; two years, assistant administrator, 150-bed voluntary hospital; one year, administrative residency; one year, administrative assistant, 350-bed hospital; experience in modernization, fund raising; nominee ACHA; available, MW 1, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Lay; nine years experience; personal member A.H.A.; desires position, hospital 24 to 150 beds; experience in equipping and staffing; will consider superintendent position. Reply, MW 99, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Medical; four years experience, assistant, large municipal hospital; one year experience, superintendent, 170-bed tuberculosis hospital; member A.H.A.; age 37, married, family. MW 8, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST — Experienced; qualified; wishes position as nurse anesthetist with no obstetrical anesthesia required; excellent references furnished. MW 13, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PHARMACIST Chief; Master's Degree; age 33; experienced; welcome opportunity to teach; city under 200,000 preferred; available about 45 days. Reply, MW 11, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.



The Medical Bureau

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ADMINISTRATOR M.B.A., Hospital Administration; year's administrative residency and three years, assistant administrator, large teaching hospital; six years, director, 300-bed teaching hospital; member ACHA.

ADMINISTRATOR Medical; degrees, including Master's cum laude in Hospital Administration, from leading universities; five years, assistant director, university hospital, 350 beds, on faculty school of hospital administration.

ADMINISTRATOR Graduate nurse; B.S., Nursing; M.B.A., Hospital Administration; three years, director of nurses, university hospital; six years, assistant administrator, 450-bed hospital.

PATHOLOGIST Diplomate; trained at university medical center; two years, assistant professor of pathology, university medical center; six years, director of pathology, 375-bed general hospital.

MEDICAL BUREAU—Continued

PERSONNEL DIRECTOR B.A., six years, personnel director, large industrial company; three years, personnel director, 300-bed hospital.

RADIOLOGIST Diplomate; six years, director, radiology, general hospital, 300 beds; five years, chief department, teaching hospital, associate professor of radiology, medical school.

SOCIAL WORKER B.A., Sociology; M.S.W.; nine years' experience as social worker, public and private agencies; three years, university teaching.



Founders of the counseling service to the medical profession, serving medicine with distinction over half a century.

ADMINISTRATOR B.S., Business Administration; 18 months, hospital business manager; 3 years, director, general hospital, 175 beds; past 6 years, administrator, general hospital, 300 beds; very active national hospital affairs; middle 30's; member, ACHA.

ADMINISTRATOR B.A., M.H.A.; 4 years, assistant director, 1200-bed university hospital; 1 year, administrator, voluntary general hospital, 250 beds, and faculty lecturer in public health; interested hospitals 200 beds up, preferably with teaching program; middle 30's; member ACHA.

ADMINISTRATOR Three years, assistant administrator, general hospital, 150 beds; 2 years, administrator, general hospital, during which time hospital expanded from 50 beds to 100 beds; 3 years, administrator, general hospital, 200 beds; middle 30's; nominee, ACHA.

ADMINISTRATOR Medical; Diplomate, American Board, Internal Medicine; past several years, associate professor, medicine, important medical school; seeks directorship, medicine, large hospital, preferably with teaching connections, or full time research.

ADMINISTRATOR R.N., B.S., M.H.A.; 33; 6 years, administrative and general duty nurse, USANC; year's administrative residency, fairly large general hospital; since September, 1952, assistant administrator, important university hospital; seeks opportunity as administrator smaller hospital.

PATHOLOGIST Degrees leading eastern schools; Diplomate, American Board, Pathology; experience includes 3 years, pathologist, important teaching hospital and assistant professor, pathology, leading medical school; seeks directorship, large laboratory in hospital; late 30's; draft exempt.

(Continued on page 200)

WOODWARD—Continued

RADIOLOGIST Diplomate, Diagnostic and Therapy; trained university hospitals; 2 years, associate radiologist, university hospital; past 18 months, director, department radiology, general hospital, 250 beds; middle 30's; Category IV.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
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NURSE SUPERINTENDENT — 15 years' experience; highly recommended; available September.

ADMINISTRATOR M.H.A. Degree; 12 years administrator, 150-bed Illinois hospital; experienced in directing building program.

ADMINISTRATOR C.P.A. Degree; 6 years public accountant; 3 years' assistant manager, 400-bed hospital; 5 years' administrator, 225-bed eastern hospital.

BUSINESS MANAGER B.S. Degree, Marquette University; 5 years' experience, mid-western hospital.

EXECUTIVE HOUSEKEEPER — Course in institutional management; 7 years experience, 300-bed hospital, New York; 2 years, 400-bed Ohio hospital.

PERSONNEL DIRECTOR — B.S. Degree, Personnel Management; 3 years, large mid-western hospital; administrative assistantship considered.

POSITIONS OPEN

ADMINISTRATOR Nurse; with some experience; 35-bed hospital; 40-hour week, vacation and sick leave; degree not necessary; salary open. Write, Mrs. C. E. Howe, Procurement Committee for McCray Memorial Hospital, 404 South Main Street, Kendallville, Indiana.

ANESTHETIST Nurse; for approved pediatric hospital. Write, Administrator, Milwaukee Children's Hospital, 721 North 17th Street, Milwaukee 3, Wisconsin.

ANESTHETIST Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write, Robert M. Jones, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETIST Nurse; wanted to work in anesthesia department, general hospital with 155 beds; good working conditions; 4 nurse anesthetists on staff at present time; salary \$400 base, plus overtime. Contact Miss Ora Hartley, Head Anesthetist, or the Personnel office at Beyer Memorial Hospital, Ypsilanti, Michigan.

ANESTHETIST Nurse; for 240-bed hospital; salary open; partial maintenance provided. Apply, Administrator, Charleston General Hospital, Charleston, West Virginia.

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POSITIONS OPEN

ANESTHETIST—Nurse; 200-bed hospital; attractive employment conditions; salary open. Reply, stating age and experience, to J. M. Schwab, M.D., Chief of the Department of Anesthesiology, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

ANESTHETIST—Registered nurse; 135-bed modern general hospital, including professional building accommodating twenty specialists in the various fields of medicine and surgery; situated in nice section of Detroit; good remuneration. Willis J. Gray, Director, Jennings Memorial Hospital, 7815 East Jefferson Avenue, Detroit 14, Michigan.

ANESTHETIST—Nurse; well qualified; to work with clinic group; salary open, based on experience; all types of surgery; two hospitals associated with group, with total capacity of 150 beds. Carbondale Clinic, Carbondale, Illinois.

ANESTHETIST—Nurse; wanted immediately for an established general hospital, A.C.S. approved; 120 beds; beautiful surroundings, close to stores and theaters; salary \$350 to \$375 per month plus maintenance; liberal vacation; sick allowances. Apply: A. G. Stasel, Administrator, Eitel Hospital, 1375 Willow Street, Minneapolis, Minnesota.

ANESTHETIST—Nurse; for 150-bed general hospital; 40-hour week; extra pay for call duty; four weeks' vacation plus six holidays; salary open. Memorial Hospital, Roxborough, Philadelphia 28, Pennsylvania.

ANESTHETIST—200-bed AMA and ACS approved general hospital; new and modern; department headed by anesthesiologist; salary open, dependent upon experience. Write: B. W. Mandelbaum, M.D., Administrator, Mount Sinai Hospital, Minneapolis, Minnesota.

ANESTHETIST—Nurse; A.A.N.A.; 110-bed hospital; salary \$400 per month; two anesthetists employed; large variety of surgery. Write, wire or call collect, Harold W. Peterson, Administrator, Northwestern Hospital, Thief River Falls, Minnesota.

ANESTHETISTS—Three; 100-bed acute general hospital, large volume of surgery; pleasant working environment, modern equipment, air-conditioned operating room; 40-hour week except for every third week; vacations, sick leave, social security; small town in east; salary \$350 per month. Apply, MO 41, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETISTS—Three; immediate openings available; located in New York City; all types of surgery (no obstetrics); salary \$4800-\$6000 per year; 1 month vacation at end of each year; 2 weeks sick leave per year; quarters available in residence, \$425 annually. Apply, The Roosevelt Hospital, 428 West 59th Street, New York 19, New York.

ANESTHETISTS—Nurse; two; for new 130-bed hospital; salary \$350 to \$400 and full maintenance, based on experience. Apply to: Administrator, Pitt Memorial Hospital, Greenville, North Carolina.

ANESTHETISTS—Nurse; two vacancies immediately available; full time medical anesthetist in charge of department; new modern 115-bed hospital. Mount Sinai Hospital, Hartford, Connecticut.

ANESTHETISTS—Nurse; for approved general hospital; good personnel policies; full maintenance; vacation; attractive salary; exceptionally good working conditions. Apply: Administrator, Randolph Hospital, Inc., Asheboro, North Carolina.

DIETITIAN—September opening for therapeutic dietitian; 250-bed hospital, central Connecticut; includes formal and clinical teaching; approved school of nursing. Reply, MO 43, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Therapeutic, teaching; ADA, experienced preferred; for 400-bed hospital, teaching nutrition and diet therapy; one class annually averaging 40 students; salary commensurate with training and experience; four weeks vacation; sickness benefits, retirement plan, social security; forty-hour week, every other Saturday and Sunday off. Apply, Director of Dietetics, Rochester General Hospital, 501 West Main Street, Rochester 8, New York.

(Continued on page 202)

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THE COCA-COLA COMPANY

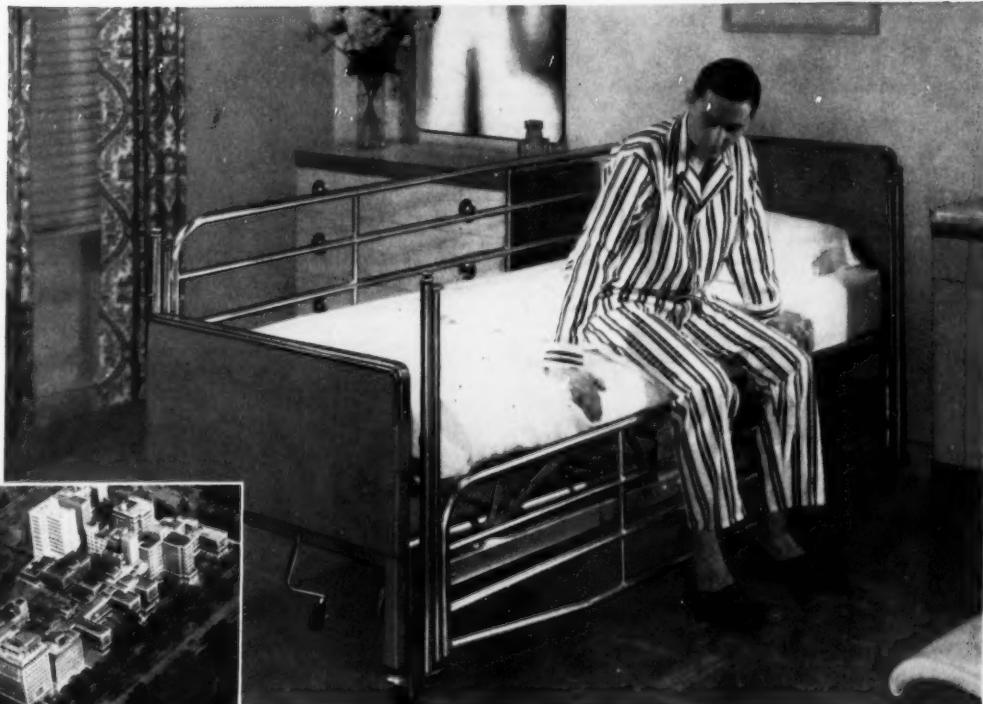


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POSITIONS OPEN

DIETITIAN—For 150-bed general hospital, school of nursing; central food service; 40-hour week; good working conditions; salary open. Contact, Ruth Brant, Martins Ferry Hospital, Martins Ferry, Ohio.

DIETITIAN—Teaching; A.D.A.; 329-bed hospital, 150 student nurses; previous hospital and teaching experience desirable; 40-hour week; paid vacation and sick leave; social security; salary open. Apply: Deaconess Hospital, Buffalo 8, New York.

DIETITIAN—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbelton, New Brunswick, Canada.

DIETITIAN—Wanted immediately for 110-bed hospital requiring reorganization of dietary department in connection with construction under Hill-Burton Act; \$250 per month beginning salary. Apply to Harold W. Peterson, Administrator, Northwestern Hospital, Thief River Falls, Minnesota.

DIETITIAN Administrative and therapeutic; 208-bed hospital; salary open; 40-hour week; 7 paid holidays, sick leave, 2 weeks paid vacation annually; group insurance; social security. Communicate with Personnel Director, Virginia Mason Hospital, Seattle, Washington.

DIETITIAN—Associate, with minimum of three years' experience in administrative and therapeutic dietetics; immediate opening in 200-bed general hospital located in suburban town close to Chicago; \$350 per month, plus complete maintenance for ADA member. Write full particulars about yourself to Miss M. Schoenick, Memorial Hospital, Elmhurst, Illinois.

DIETITIAN—Staff; 165-bed private general hospital with young staff; conveniently located in medium-sized city; prefer ADA membership; no experience necessary; some therapeutic and some administrative work on staff of three; 40-hour week; newly remodeled kitchen; salary open, meals, laundry, insurance furnished. Apply, Personnel Director, Flower Hospital, Toledo, Ohio.

DIETITIAN Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIANS Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary \$270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

(Continued on page 204)

DIRECTOR OF NURSES New 85-bed hospital in southern Illinois town of 6000; 44-hour week, paid vacation, sick leave; salary open. Reply, MO 46, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—Assistant; in a 441-bed institution located in Delaware; Degree in Nursing Education required; salary depends upon qualifications and experience; maintenance and apartment included. Apply to Director of Nurses, Delaware Hospital, Wilmington, Delaware.

DIRECTOR OF NURSING—Assistant; for new 215-bed general hospital opened January, 1953; modern hospital facilities; 40-hour week; excellent salary; hospital will be used as field for clinical experience for junior college nursing students; please give resume of past experience and academic preparation in nursing; include small photograph if possible. Apply, Director of Nursing, Oakwood Hospital, 18101 Oakwood Boulevard, Dearborn, Michigan.

DIRECTOR OF NURSING Applications are being accepted for this position in 400-bed capacity hospital, including 71-bed chronic wing; this position would include the over-all supervision of nursing and education with associate director for school of nursing, 94 students, and assistant in nursing service. Applications, stating qualifications and experience, should be addressed to the Administrator, Kitchener-Waterloo Hospital, Kitchener, Ontario, Canada.



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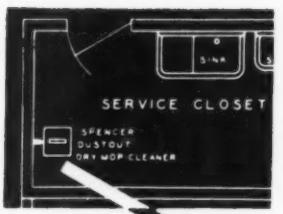
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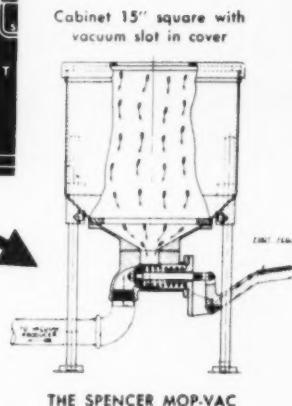
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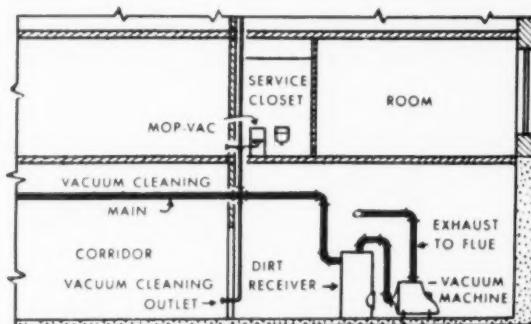
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DIRECTOR OF NURSING AND PRINCIPAL OF THE SCHOOL OF NURSING Applications are invited for this position by Royal Columbian Hospital, New Westminster; 432 beds; duties consist of directing nursing services and accredited school of nursing of approximately 175 students; teaching and administrative experience required; prefer minimum of five years as director or assistant director experience; excellent remuneration. Please reply fully giving details of nationality, training, experience, age, etc., to Secretary, Board of Directors, Royal Columbian Hospital, New Westminster, British Columbia, Canada, not later than August 31, 1955.

DIRECTOR, SCHOOL OF NURSING School of 75-85 students; class admitted annually; three affiliations: psychiatry, tuberculosis and pediatrics; full accreditation by National Nursing Accrediting Service; M.S. preferred, B.S.

considered; experienced; 44-hour week; 6 holidays, 30 days vacation annually; social security; Blue Cross and Blue Shield; salary open for negotiation; 250-bed, voluntary, general hospital. Apply to L. C. Pullen, Jr., Administrator, Decatur and Macon County Hospital, Decatur, Illinois.

FOOD SERVICE DIRECTOR For a 250-bed hospital located in a midwest city; must be experienced in planning meals, supervising kitchens, personnel, and analyzing costs; good working conditions and pleasant surroundings; salary open, depending on qualifications and experience. Reply, MO 42, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR-SUPERVISOR Clinical; operating room; postgraduate and/or degree preferred; individuals with teaching and supervisory experience will be considered; excellent personnel policies, including 40-hour week, 6 paid holidays, social security, 6-month increments, 28 calendar days (20 working days) vacation. Apply, Director of Nursing, St. Luke's Hospital, Toledo 10, Ohio.

INSTRUCTOR Clinical, in public health nursing, for an opening in the outpatient department; a Degree in Nursing Education, with emphasis on public health nursing, is essential; salary depends upon qualifications and experience. Apply to Director of Nurses, Delaware Hospital, Wilmington, Delaware.

INSTRUCTOR Clinical; for medical and surgical nursing; degree and experience required. The Toledo Hospital School of Nursing, North Cove Boulevard, Toledo 6, Ohio.

(Continued on page 206)

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is increasing!**

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The advertisement features a large black and white photograph of a modern hospital building with multiple wings and a flat roof. In the foreground, a sign reads "LUDMAN Auto-Lok AUTOMATIC LOCKING PATENTED SPECIAL HOSPITAL WINDOWS". To the left of the sign, a cartoon illustration shows a nurse carrying a tray while interacting with a Ludman Auto-Lok window. Below the window, a small inset diagram shows a cross-section of the locking mechanism. The text "Busy nurses appreciate Ludman Special School Windows because they operate so easily, so smoothly—with only a finger-touch!" is written next to the nurse's illustration. At the bottom, the text "Hospital Officials! Architects! Write for complete descriptive catalog" is followed by the company name "LUDMAN Corporation" and the address "Box 4541 Dept., MH-8, Miami, Florida". The bottom of the page also contains the slogan "UDMAN LEADS THE WORLD IN WINDOW ENGINEERING".

classified advertising

POSITIONS OPEN

INSTRUCTOR-SUPERVISOR — Obstetrics; to reorganize 40-bed unit, small school with psychiatric, pediatric and tuberculosis affiliations; excellent personnel policies including 46-hour week, 6 paid holidays, 28 calendar days (26 work days) vacation, social security, hospitalization; degree and experience preferred. Apply to Director of Nursing, St. Luke's Hospital, Toledo 10, Ohio.

INSTRUCTOR-Science; for 465-bed hospital, 250 students; six science instructors in department; faculty being increased; teaching load light; salary \$3624 to \$4224; thirty-one days vacation; hospital has retirement plan in addition to social security; other liberal personnel policies; living conditions attractive; private bath; city has many cultural advantages; hospital in beautiful 40-acre park. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTORS — Clinical, in nursing education; psychiatric affiliate program for student nurses in nationally recognized 1500-bed teaching hospital; require B.S. or M.S. in Nursing Education plus 4 years experience in psychiatric nursing, of which 3 were in a supervisory and teaching capacity; salary commensurate with qualifications and experience; periodic salary increases based on merit; vacation, sick and retirement benefits. Apply, Topeka State Hospital or Kansas Department of Civil Service, Topeka, Kansas.

INSTRUCTOR — Nursing arts; immediate opening in 100-bed general hospital with fifty students; college in hospital vicinity; about 40 miles from Boston; 40-hour week; salary open; B.S. Degree required. Contact Director, School of Nursing and Nursing Service, Nashua Memorial Hospital, Nashua, New Hampshire.

INSTRUCTORS — Clinical, in medicine, surgery and pediatrics; positions available this summer at Misericordia Hospital, Edmonton, Alberta, Canada; good personnel policies; 44-hour week. Address applications and requests for further information to Director of Nursing.

INSTRUCTORS — Clinical; for formal and clinical teaching; 465-bed hospital, 250 students; faculty being increased; teaching load light; salary \$3624 to \$4224; thirty-one days vacation; hospital has retirement plan in addition to social security; other liberal personnel policies; living conditions attractive; private bath; city has many cultural advantages; hospital in beautiful 40-acre park. Apply, Director of Nurses, Reading Hospital, Reading, Pennsylvania.

INSTRUCTORS — Science, Nursing arts, and Clinical; required immediately for 208-bed pediatric hospital; new wing opening in September; nursing school of 90 students and 40 affiliates; good salaries and personnel policies. Apply, stating qualifications, to Director of Nurses, The Children's Hospital, Halifax, Nova Scotia, Canada.

MISCELLANEOUS — Assistant director of nurses and clinical coordinator; Nursing arts instructor; 300-bed, non-profit hospital, located in beautiful seaport southern city, 20 minutes to the beach, population 50,000; attractive salary and full maintenance; straight 8-hour day, 44-hour week; liberal vacation and sick leave. For information, write Director of Nurses, James Walker Memorial Hospital, Wilmington, North Carolina.

MISCELLANEOUS — Supervisors. General staff nurses; for 235-bed hospital; salary range \$225 to \$400; paid vacations; sick leave; 6 holidays; social security; population 40,000; just a short drive to Mt. Ranier. Apply, Director of Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

NURSE — Registered, qualified; female; for night supervision; salary range \$250 to \$275; excellent working conditions. For further information, write, MO 44, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE — Registered; for general duty; meals while on duty, and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

NURSES — General duty and surgical; yearly increments; accumulative sick leave, annual vacation, plus twelve legal holidays a year; salary plus maintenance; one hour from midtown New York. Apply, Director of Nurses, Valley View Sanatorium, Paterson, New Jersey.

(Continued on page 208)

maggi works magic
with flavor!

MAGGI'S SEASONING

Sleight-of-hand with a dash of Maggi's Seasoning develops food flavor to its peak and keeps it there. Old-world chefs have used this trick for years . . . making the subtle hidden flavors of soups, stews, gravies, vegetables and meat spring to life.

IN HANDY QUART SIZE
WITH "STEADY FLOW"
POURING SPOUT



MAGGI'S GRANULATED BOUILLON CUBES

Cooking magic with Maggi's Granulated Bouillon delights the most discriminating patron. Enrich gravies, sauces, vegetables and stews with economical-to-use Maggi's . . . which also makes an excellent full-flavored stock or an instant beverage.

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WHITE PLAINS • NEW YORK

maggi's
world-famous flavor products

seasoning...
granulated
bouillon cubes

BEAN SOUP...with a flavor!

1 lb. marrow beans soaked overnight • 1 ham bone • 6 oz. onions chopped • 4 oz. celery chopped • 3 1/2 qts. water • 8 oz. tomato puree • 1 tbsp. salt • 1/4 tsp. pepper • 2 tbsp. sugar • 2 tbsp. flour • 2 tbsp. shortening • 1/4 c. Maggi's Seasoning.

Cover beans with fresh water, add ham bone and vegetables. Cook until beans are tender. Strain. Add tomato puree, salt, pepper, sugar. Cook 15 minutes. Make a roux of flour and shortening; add to mixture. Add Maggi's Seasoning. Boil 3 minutes. 10 portions.

The All-Family Drink!

"Fresh up" with Seven-Up... so pure, so good,
so wholesome for everyone!



You like it... it likes you!



GET A FAMILY SUPPLY OF 24 BOTTLES.
Buy 7-Up by the case. Or get the
handy 7-Up Family Pack. Easy-lift
center handle, easy to store.



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POSITIONS OPEN

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary \$200 to \$210 month; full maintenance available for \$10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Graduate; for 12-month resort hotel with nursing care, just outside Baltimore; 8-hour day, 6-day week; salary \$225, maintenance at \$45; pleasant environment. Apply, Director, College Manor, Lutherville, Maryland.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary \$275 per month if applicant has advanced preparation or experience; \$10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Registered and Graduate: General duty and Surgery; 40-hour week; \$250 base pay, or \$15 above present tenure of service monthly salary; one meal per day; vacation, tenure of service raises, evening and night duty premiums and other personnel benefits. Write or phone collect, Administrator, Pioneer Memorial Hospital, Heppner, Oregon.

NURSES—Registered; 40-hour week; paid vacations; 8 paid holidays per year; permanent employment; starting salary for general duty, \$240 per month with \$10 differential for 3-11 and 11-7 shifts; \$5 raise every 6 months for 3 years; Arizona state registration required. For further information, contact Superintendent of Nurses, Yuma County General Hospital, Yuma, Arizona.

NURSES—Staff and operating room; 5 days, 40 hours; 8 holidays and vacation with pay; initial salary \$250 plus laundry; increases at 6, 12, 24, 36 months; additional pay for evening and night assignments and for operating calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

NURSES—The Institute of Living offers appointments to the staff of one of the most active psychiatric clinics in the country; practice and study in psychiatric nursing for graduate nurses; residence provided on campus within walking distance of downtown Hartford. Direct inquiries to: Director of Nursing, 200 Retreat Avenue, Hartford, Connecticut.

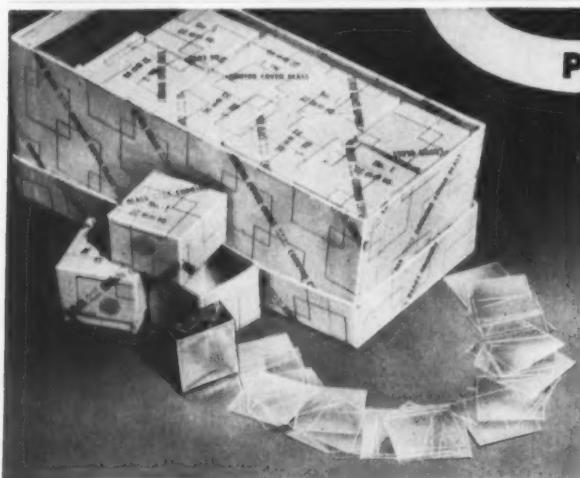
NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary \$280; \$5 per month tenure increase for each six months of service to a maximum of \$310; social security, sick leave, prepaid medical and hospital care; \$10 additional for afternoon and night shift; \$10 additional for delivery room; \$20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

(Continued on page 210)

NURSES—General staff, primarily interested in maternity or gynecologic nursing; opportunity for stimulating experience in a university hospital; cultural and recreational facilities of the university available to the nursing staff; 40-hour week; three-week vacation; beginning salary \$265 per month with \$1 per day differential for evening or night duty; permanent evening or night duty \$30 per month differential; opportunity for advancement; excellent physical plant, beautifully equipped; attractively furnished housekeeping apartments available at \$30 per month shared. Apply, Director of Nurses, University of Chicago, Lying-in Hospital, 5841 Maryland Avenue, Chicago 37, Illinois.

NURSES—To staff new general hospital; starting salary \$2400-\$2640, with merit increments; 40-hour week, 8 paid holidays, annual vacation, accumulative sick leave, retirement plan; full maintenance available at reasonable rates; ten miles from New York City. Apply, Assistant Superintendent, Bergen Pines County Hospital, Paramus, New Jersey.

NURSES—Surgical and General duty; needed at a small progressive hospital; nice location, good working conditions. For full details, write to McLaughlin Osteopathic Hospital, 619 Townsend Street, Lansing, Michigan.



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CORNING MICRO COVER GLASSES

Produced for the first time in glass technology by modern mechanical process, these *made-in-U.S.A.* Cover Glasses present an unprecedented optical quality plus a degree of uniformity superior to the tolerances allowed in present government specifications.

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In contrast to the old-world hand spinning method, which fails to control true flat surfacing or uniformity of thinness, Corning Micro Cover Glass is produced as a uniform ribbon before cutting into the various shapes. The undesirable "peaks and valleys" characteristic of conventional cover glasses are virtually eliminated.

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Corning quality optical glass is totally free from gas bubbles or extraneous "seeds." These Cover Glasses fully meet government specifications for stability in every detail.

ORDER TODAY or write for further information

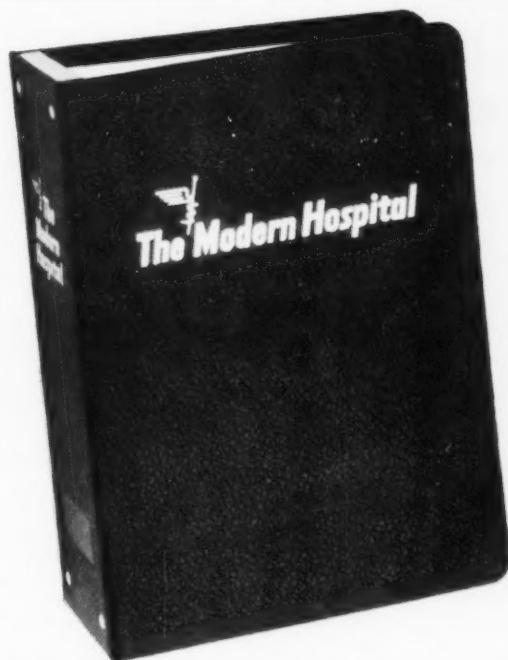
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THE SOLUTION DESIRED AT THE INSTANT REQUIRED

Cat. No. Description	Packed—half oz. boxes—10 oz. to carton, one size, shape, thickness				
	Per Oz. less than 10 Oz.	Per Oz. 10-40 Oz.	Per Oz. 50-90 Oz.	Per Oz. 100-140 Oz.	Per Oz. 150 Oz. & Over
1031 SQUARES #1					
22 mm x 23 mm	1.15	2.12	2.00	1.94	1.88
18 mm	1.39	2.33	2.20	2.14	2.07
15 mm	2.41	2.54	2.40	2.33	2.26
12 mm	2.29	2.96	2.80	2.71	2.63
1032 RECTANGLES #1					
smaller than 24 mm x 30 mm	2.35	2.12	2.00	1.94	1.88
22 mm x 25 mm	1.75	1.58	1.49	1.44	1.40
18 mm	1.93	1.74	1.64	1.59	1.54
15 mm	2.10	1.89	1.79	1.73	1.68
12 mm	2.43	2.21	2.08	2.02	1.96
1033 RECTANGLES #2					
smaller than 24 mm x 30 mm	1.75	1.58	1.49	1.44	1.40
22 mm x 25 mm	1.75	1.58	1.49	1.44	1.40
18 mm	1.93	1.74	1.64	1.59	1.54
15 mm	2.10	1.89	1.79	1.73	1.68
12 mm	2.43	2.21	2.08	2.02	1.96
1034 CIRCLES #1					
22 mm x 25 mm	4.11	3.70	3.49	3.29	3.29
18 mm	4.33	4.08	3.85	3.74	3.62
15 mm	4.74	4.43	4.20	4.08	3.95
12 mm	5.76	5.18	4.90	4.75	4.61
1037 CIRCLES #2					
22 mm x 25 mm	3.06	2.75	2.60	2.52	2.45
18 mm	3.38	3.04	2.87	2.79	2.70
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**NOW A NEW BINDER
for "The Modern Hospital"**
HOLDS 6 ISSUES

Protect your copies of "The Modern Hospital" with these modern Vulcan Binders! One binder will hold 6 copies, two binders will hold a complete year's issues, 12 issues in all. Binders are made of heavy-weight board and are covered with dark blue, drill quality, imitation leather stamped in gold foil. Backbone panel gives space for labeling volume and year. Individual wires hold each issue securely, make insertion easy.

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WORLD'S LARGEST MANUFACTURER OF CURRENT ISSUE
MAGAZINE BINDERS FOR RECEPTION ROOMS.

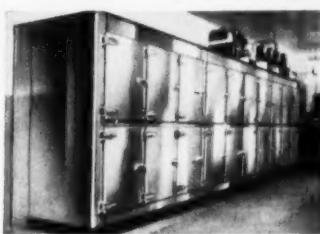
HERRICK
STAINLESS STEEL REFRIGERATORS
Performance-Proved
at the world-famous
HOTEL CONRAD HILTON
in Chicago



At left is an exterior view of Chicago's magnificent Hotel Conrad Hilton. Occupying half a city block on Michigan Ave., it overlooks Grant Park and affords a beautiful view of the lake. It's America's favorite meeting place.



At right is a HERRICK Freezer Refrigerator used for preserving parfaits and frozen desserts. HERRICK Stainless Steel Refrigerators also serve the Hotel Conrad Hilton's coffee shops and cocktail lounges.



At left is a HERRICK 20-Door Refrigerator serving the Hilton's Banquet Kitchen. It keeps foods at peak freshness and flavor. HERRICK units were supplied by Duparquet, Inc., 225-235 N. Racine Ave., Chicago, Ill.

Largest of all in size and second to none in service, the Hotel Conrad Hilton offers visitors to Chicago the ultimate in gracious living. Its many dining rooms, coffee shops and cocktail lounges are justly famous for their fine foods and beverages. • Helping to enhance the Hilton's reputation in this respect are a number of HERRICK Stainless Steel Refrigerators, two of which are shown above. Wherever complete food and beverage conditioning is called for, HERRICK Stainless Steel Refrigerators will do a perfect job! HERRICK is unequalled for performance, convenience and low-cost-per-year service. Write today for name of your HERRICK supplier.

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DEPT. M. COMMERCIAL REFRIGERATION DIVISION**

HERRICK

The Aristocrat of Refrigerators

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POSITIONS OPEN

CLINICAL PATHOLOGIST AND DIRECTOR OF LABORATORIES For 432-bed, fully approved hospital; 4 weeks annual vacation, 5-day week, sick benefits, etc.; salary \$9000-\$12,000, depending on experience and qualifications. Please reply fully, giving details of training, experience, age, etc., to Secretary, Board of Directors, Royal Columbian Hospital, New Westminster, B. C., Canada.

SALESMAN Surgical supply; to live in Shreveport, Louisiana; must be experienced in selling equipment and supplies to doctors and hospitals. Reply by letter, stating experience, age, salary, and including recent photo: Williams' Physicians and Surgeons Supplies, Box 706, Shreveport, Louisiana.

SALESMAN Hospital; leading manufacturer of maintenance, sanitary and floor treatment chemicals requires experienced, strictly commission, institutional sales producer; five-figure per annum opportunity; permanent. Reply, MO 45, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SALESMEN Selling to hospitals; side line, expendable product, repeat business, commission. Reply, MO 46, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR And Clinical instructor for pediatrics; experience and advanced preparation necessary, preferably a degree; for modern 250-bed hospital, fully approved, 70 miles from New York City; 40-hour week; 3 weeks paid vacation; sick time; hospital care; complete maintenance, if desired, at \$45 per month; beginning salary \$365 per month. Apply, Director of Nursing, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISOR Operating room; 400-bed hospital averaging 550 operations a month; school of nursing accredited by National League for Nursing; administrative and teaching duties; salary dependent upon educational qualifications and experience; vacation four weeks, sick leave two weeks annually; retirement plan. Write, Director of Nursing, The Rochester General Hospital, Rochester 8, New York.

SUPERVISOR Night; private psychiatric sanatorium; 5-day week; social security; hospitalization; all holidays; laundry; good salary; pleasant surroundings; Licensed practicals for staff, all shifts open. Write, Director of Nurses, Fair Oaks Sanatorium, Summit, New Jersey.

SUPERVISOR Operating room; for 110-bed general hospital; salary open; large variety of surgery. Apply to Harold W. Peterson, Administrator, Northwestern Hospital, Thief River Falls, Minnesota.

(Continued on page 212)

FOR EASIER FLOOR UPKEEP



For floor finishing or daily maintenance, Brillo solid-disc steel wool floor pad hardens and brightens finish. Regular once-over removes traffic grime—renews gloss quickly without rewaxing. Equally efficient for linoleum, asphalt or rubber tile, wood, and terrazzo.

For free folder on low-cost Brillo floor care, write to Brillo Mfg. Co., Dept. M, 60 John St., Brooklyn 1, N. Y.

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cleans and buffs
in one operation
SAVES TIME

... does the job
faster—without
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SAVES LABOR

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SOLID-DISC STEEL WOOL
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**Save you
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1 Tested to give best service under your conditions.

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3 Original beauty lasts through countless washings.

4 Variety of styles for every Hospital use.

5 Direct from Mill policy gives you more value per dollar.

See your Kenwood representative or write direct to the Mill for swatches, prices and full information.

**KENWOOD
MILLS**

CONTRACT DEPT.
RENSSELAER,
NEW YORK



SUPERVISOR Obstetric; B.S. Degree preferred; 180-bed general hospital; 40-hour week; 4 weeks' vacation and 2 weeks' sick leave; minimum salary \$3500 per year. Apply, Director of Nurses, William W. Backus Hospital, Norwich, Connecticut.

TECHNICIAN — Laboratory; experienced in clinical pathology, for new 450-bed hospital; excellent working conditions; attractive salary adjusted to experience; 40-hour week; paid vacation; retirement benefits; full maintenance available at low cost. Send résumé and recent photo to Personnel Office, Sunny Acres Hospital, Richmond Road, Cleveland 22, Ohio.

TECHNICIANS — For general laboratory work; in 338-bed hospital; salary dependent on qualifications. Apply: Pathologist, York Hospital, York, Pennsylvania.

THERAPISTS — Two staff openings for chief physical therapist and assistant therapist; experience in polio cases desirable; excellent opportunity in 200-bed hospital; good starting salaries; located between Denver and Yellowstone Park. Apply, Personnel Director, Memorial Hospital, Casper, Wyoming.

Not ALL the Medical "Miracles" are new!

What would hospitals do without Pure Ethyl Alcohol?



Pure Ethyl alcohol is such an old friend of hospitals and the medical profession that we sometimes take it for granted. But if modern medicine were suddenly to stumble upon it as a new discovery — with its many uses, its abundant supply at low cost, and its purity — it would mark an important milestone. Fortunately, there is no waiting to explore the many possible uses for Pure Ethyl Alcohol. These uses have been proven.

The only requirement now is to make certain you get ethyl alcohol of absolute purity. The name: "U.S.I. Pure Alcohol U.S.P." is your assurance of the purity you want.

Before it reaches your pharmacy, store-room, laboratory or operating room, U.S.I. Pure Alcohol U.S.P. must pass not only all the tests prescribed by U.S.P., but also tests especially developed by U.S.I. that are even more exacting. Thus freedom from even traces of harmful impurities — acids, alkaloids, fusel oils, aldehydes, and many others — is absolutely assured.

Use only ethyl alcohol of the highest purity obtainable in your hospital. You can be sure when you specify U.S.I. Pure Alcohol U.S.P. — the choice of hospitals everywhere.

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POSITIONS OPEN



The Medical Bureau

M. BURNEICE LARSON—DIRECTOR
(FOUNDER OF THE COUNSELING SERVICE FOR THE PHYSICIAN)

PALMOLIVE BUILDING CHICAGO

ADMINISTRATORS (a) Medical; university hospital, 350 beds; plans being completed for new medical center including *new hospital of considerably greater capacity. (b) Medical; 800-bed general hospital affiliated medical school; large city, important medical center. (c) Private, non-profit hospital, 300 beds; medical school affiliation; expansion program; large city, important medical center, west. (d) Voluntary general hospital; construction to commence spring of 1954; completion expected spring of 1956; medical school affiliation; preferably administrator available by October. (e) Voluntary, general hospital, 300 beds; metropolitan area of east. (f) Small, general hospital; resort town, south. (g) New community hospital, 100 beds, currently in blueprint stage; preferably administrator experienced fund raising; residential town, east. (h) Assistant director in charge of business management; 400-bed hospital, affiliated medical school; building program; accounting background required; \$8000. MH8-1.

MEDICAL BUREAU—Continued

ADMINISTRATORS—NURSES. (a) Voluntary, general hospital, 65 beds; college town, near university center, midsouth. (b) New 100-bed hospital for children; currently under construction; university medical center. (c) Assistant administrator; general hospital, 400 beds; midwest. MH8-2

ANESTHETISTS—(a) Two; general hospital opening new wing increasing capacity to 500; city of 200,000, hour's drive from New York City; \$400-\$500. (b) To administer anesthetics for two Board surgeons; university town, midwest; \$500, maintenance. (c) New, general hospital, 125 beds; college town, south; \$425-\$500. (d) Two; group of anesthesiologists; university city, southwest. MH8-3

BLOOD BANK NURSES Important university hospital; training unnecessary; should be interested specializing new field; apartment available, modern, attractive residence. MH8-4

CLINIC, COLLEGE NURSES (a) Director, student health; coeducational, liberal arts college; midwest. (b) Clinic; long established group; California. (c) Director, student health, social program; 400-bed hospital; college town, east. MH8-14

DIETITIANS—(a) Chief and assistant; voluntary general hospital, 175 beds; new dietary department; university town, east; \$5000-\$3000 respectively, complete maintenance. (b) To take charge of cafeteria, new hospital, 400 beds; university group, west. (c) Voluntary general hospital, 275 beds; to be opened for

MEDICAL BUREAU—Continued

operation midsummer; Pacific coast. (d) Ph.D. in foods with college teaching experience; university faculty appointment. (e) Administrative; 300-bed general hospital; teaching affiliations, college town adjacent large medical center; east; minimum \$5500. (f) Therapeutic and assistant dietitians; one of country's leading private practice clinics. (g) Chief; Central America. MH8-5

DIRECTORS OF NURSES—(a) Voluntary, general hospital, 500 beds; school of outstanding reputation; teaching affiliations; college town, 60,000, east. (b) University school; Master's or Ph.D., qualified develop four-year program; \$7000-\$8000. (c) New hospital, 400 beds, affiliated medical school; west. (d) Assistant director, qualified supervise educational programs; university group. (e) Nursing service; modern hospital, 100 beds; small resort town, east. (f) Nursing service; 600-bed university hospital; although independent administratively from school, highest cooperation between school and service; substantial salary, private apartment; east. (g) New tuberculosis sanatorium, 500 beds; unit university group; large city, important teaching center. MH8-6

EXECUTIVE DIRECTOR—Assistant executive director and, also, public relations consultant; nurses association; nurses with degrees required. MH8-7

EXECUTIVE HOUSEKEEPER—New general hospital currently under construction, 400 beds, affiliated medical school; west. MH8-8

(Continued on page 214)

THAT'S MY BABY

Mothers feel safer . . . and so does the hospital staff—when Deknatel, *the original "Name-On" Beads* are used for baby identification. They are sanitary, inexpensive, virtually foolproof. That's why hospitals prefer them. For more than 30 years leading hospitals have used them, with confidence.

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THE ORIGINAL "NAME-ON" BEADS
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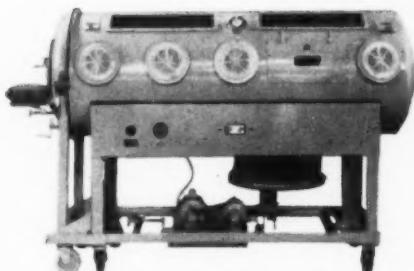
Other Deknatel Products—Deknatel Surgical Silk and Nylon, Minimal Trauma Needles with attached Sutures.

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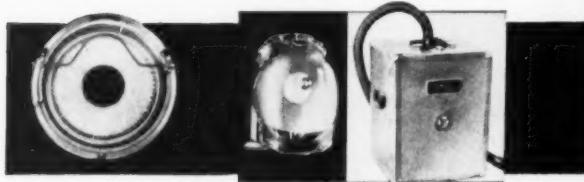
QUEENS VILLAGE 29, (L. I.) N. Y.

FABRIKATORS'
"CHESTPIRATOR"

The portable respirator
that has **EVERYTHING!** . . .

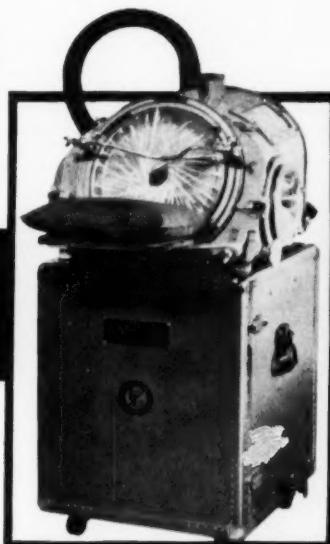


FABRIKATORS' RESPIRATORS combine time-tested reliability with important advances. Equipped with Spiratwist plastic collar and tracheotomy bar, silent, valve controls, self-tilting headrest — full tilting, rotating and elevating action. New plastic armports optional at added cost.

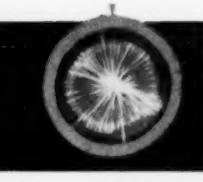


SPIRATWIST Plastic Collar — fits all respirators—all neck sizes. Has fully adjustable tracheotomy bar. Disposable — it provides maximum comfort at lowest possible cost.

RESPIRAIR (portable) Plastic Respirator. Compact power unit and plastic chestpieces in 6 sizes. Unique, plastic diaphragm maintains high pressures — makes the Respirair ideal for transportation or treatment of your recovering patients.



The Armed Services use Chestpirator for transportation and treatment.



SPIRATWIST Plastic Armports fit all respirators. Opens wide with one hand—locks automatically when closed. Disposable — use as supplementary catheter openings as well.

Fabrikators' INC., OF MASS.

Nineteen Walnut Street West Roxbury 32, Mass.
LICENSEE AND SELLING AGENT — IRON LUNG CO. OF AMERICA



The Chestpirator is accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association — and is listed under the re-examination service of the Underwriter's Laboratories. ALL types shown are easily converted to hand operation.

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—Continued

EXECUTIVE PERSONNEL—(a) Office manager; strong accounting background; 350-bed general hospital; university city, midwest. (b) Purchasing agent; 200-bed hospital; southwest. (c) Business manager with accounting background and, also, assistant personnel director; fairly large hospital recently completed; west. (d) Comptroller, qualified as business manager; new hospital; \$10-\$12,000; midwest. MH8-9

FACULTY APPOINTMENTS—(a) Assistant professors in following specialties: neuropsychiatric, obstetrical, medical, surgical nursing; four-year program; leading university. (b) Assistant professor in clinical instruction; east. (c) Assistant dean and assistant professor of nursing; west. (d) Nursing arts and medical clinical instructors; positions carry faculty appointments at university level; Pacific coast. (e) Science instructor; small school; \$400, including apartment; vicinity Washington, D.C. (f) Nursing arts; small school; Virginia; \$335, maintenance. (g) Clinical instructor, pediatrics; leading hospital; California; \$400. (h) Assistant professor; state college; programs designed to prepare nurses for teaching and health education; west. MH8-10

MEDICAL BUREAU—Continued

RECORD LIBRARIANS—(a) Chief and assistant; voluntary general hospital; average census 400; 40-hour, 5-day week; New England; \$4000-\$4800. (b) Chief; one of leading hospitals; southern California. (c) Chief and assistant; new 400-bed hospital affiliated university medical school; west. MH8-11

STAFF AND SURGICAL NURSES—(a) Two staff; Pacific Islands; \$4290, apartment (shared), transportation. (b) Staff; hospital of industrial company; Pacific Northwest. (c) Neurosurgical nurse; surgical clinic; university city, south. MH8-12

SUPERVISORS—(a) Operating room; 400-bed hospital; extensive experience, teaching ability required; \$5900 increasing to \$6500 second year. (b) Pediatric; 40-bed department; 300-bed hospital; collegiate program; Pacific coast. (c) Obstetrical; new air-conditioned unit, 400-bed hospital; medical center, south. (d) Night and evening supervisors; small general hospital; outside United States; although tropical country, climate mild. (e) Pediatric and obstetrical; new 400-bed hospital affiliated medical school; west. (f) Senior surgical supervisor; teaching hospital, service principally surgical; university center. (g) Assistant director, operating room; department staff of 30 professional nurses; teaching hospital; east. (h) Orthopedic; new department; 300-bed hospital; college town; midwest. MH8-13

(Continued on page 216)



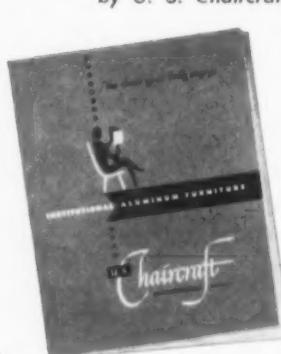
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ADMINISTRATORS—(b) Medical; important teaching hospital, large size; east. (c) Lay; one adroit in public relations; voluntary general hospital, fairly large size; to \$15,000; east. (d) Lay; one of west coast's finest children's hospitals; medical school affiliated; large city; to \$20,000. (g) Lay; voluntary general hospital, 150 beds; college town 100,000; midwest. (h) Lay; newly opened voluntary general hospital, 180 beds; cooperative Board; requires outstanding man; college city 250,000; New England. (i) Lay; assistant; 400-bed hospital; medical school affiliated; large city; midwest. (l) Lay; general hospital, 50 beds, recently opened; \$5000; central.

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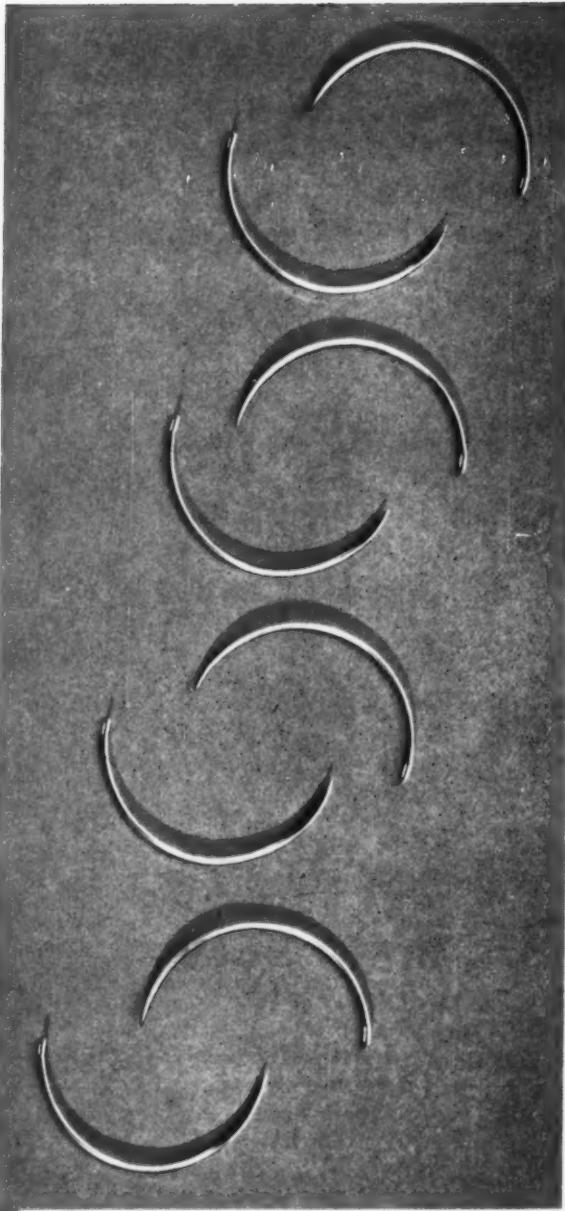
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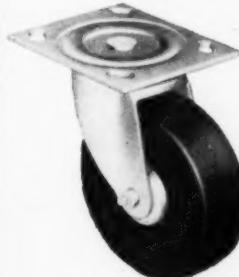
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WOODWARD—Continued

CLINIC MANAGERS—(a) Group founded by 19 distinguished men long established; all Diplomates; expansion program; \$7000 initially; rapid increases; city 100,000; east. (b) Group 14 men long established; outstanding facilities; very desirable town; California. (c) One with long experience in clinic management; 9 highly qualified specialists; complete facilities; new building; lovely college town, 35,000; central.

ADMINISTRATORS—NURSES.—(a) General hospital, 50 beds; established 1948; \$5000 plus maintenance; desirable university town 40,000; northwest. (b) Convalescent children's hospital, 50 beds; requires M.S. in field related to service; public health administration, nursing or social service; about \$5000; Washington, D.C., area.

ANESTHETISTS—(a) Voluntary general hospital, small size; \$7200; large city, university medical center; central. (b) Two required; important voluntary general hospital, 500 beds; \$6000; New England. (c) Group distinguished men; 60-bed hospital; \$6600; southeast. (d) Group 15 men mostly certified; large amount major surgery; to \$600; midwest. (e) Two required; university hospital; \$475; midwest.

WOODWARD—Continued

DIETITIANS—(a) Chief; one of outstanding hospitals on west coast, newly completed; 225 beds; very modern dietary department; large city; university medical center. (c) Assistant administrative, assistant clinic and ward supervising dietitians; large general hospital affiliated university medical school; university medical center; south. (d) Nutritional advisor; diet consultations with employees; major industrial company; prefer under 30; ADA; 40 hours; about \$275 initially; university medical center city; east. (f) Assume full charge cafeteria and coffee shop; university hospital newly opened; \$400; city 600,000; very important university medical center; southwest.

DIRECTORS OF NURSES—(b) General voluntary hospital, 500 beds; university medical school affiliation; \$6000; metropolis; east. (c) Nursing service and education; voluntary general hospital, 500 beds; B.S. minimum with 3 years experience; \$6000; large city; university medical center; midwest. (g) Nursing service only; voluntary general hospital, 200 beds; prefer B.S. but not necessary; \$4800 plus full maintenance including lovely 3-room apartment; Wisconsin.

EXECUTIVE HOUSEKEEPERS—(a) University hospital, large size; staff of 70 including 6 assistant housekeepers; \$4500; excellent housing. (b) Hotel; exclusive resort; 160 rooms; 14 cottages; \$250 plus full maintenance; large bonus; staff of 25; lovely coastal town; California.

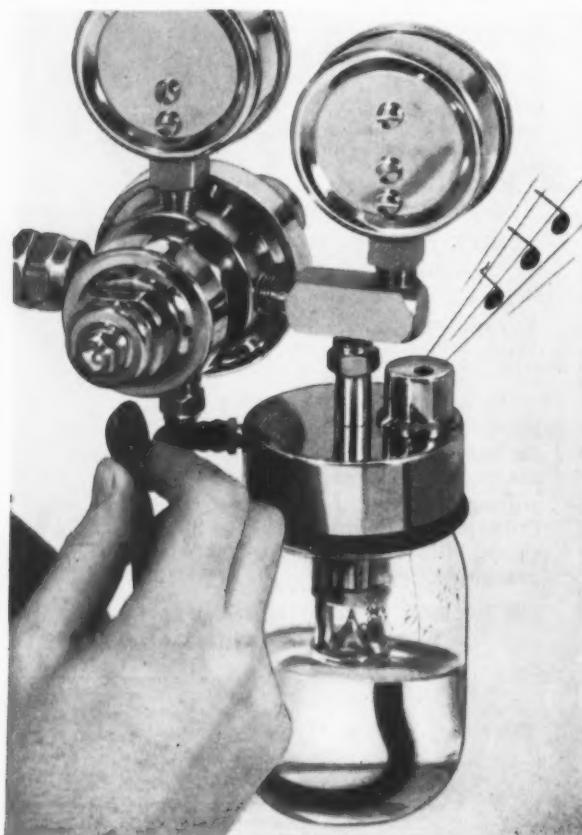
(Continued on page 218)

WOODWARD—Continued

FACULTY APPOINTMENTS—(a) Assistant dean; direct university program; full charge; south. (b) Assistant professor; 125 students; university program. (d) Educational director; to develop complete program; voluntary general hospital, 230 beds; 1 hour to New York City. (e) Associate educational director; 45 students; college affiliation; 200-bed hospital; west. (g) Clinical instructor in surgical and orthopedic nursing; 90 students; NNAs; classroom and clinical teaching and ward supervision; full faculty status; university hospital; west coast. (h) Obstetrics instructor; voluntary general hospital, 350 beds; excellent faculty; large city; university medical center; California. (j) Nursing arts instructor; 80 students; about \$450; east. (k) Science instructor; medical student teaching; course considers viruses; university program; to \$5,000; opportunity research; large city; university medical center; west.

PUBLIC HEALTH—STUDENT HEALTH—(c) Public health supervisor; town 50,000; \$4000 plus car expenses; Wisconsin. (d) Student health nurse; boys' academy; 170 students; nice infirmary; exclusive boys' school near Chicago.

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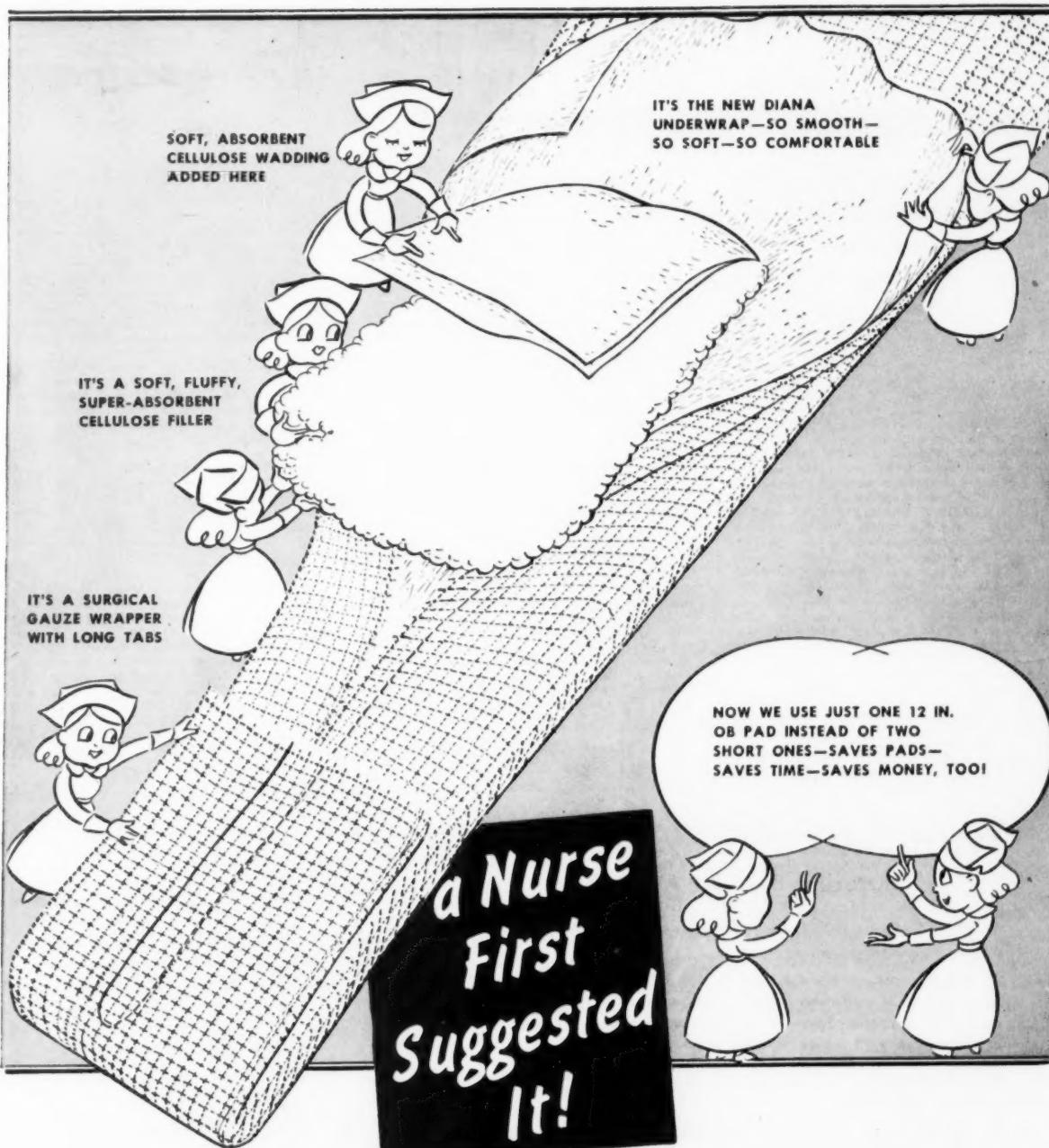
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WOODWARD—Continued

RECORD LIBRARIANS (a) Chief; general hospital; small size; excellent modern facilities; fine town 25,000, 2 miles from ocean; California. (b) Three required; 1 as associate to chief; 1 as senior and 1 medical record librarian; 1500-bed teaching hospital; tourist city 400,000; Canada. (c) Chief; voluntary general hospital, 400 beds; facilities complete and outstanding; \$400; New England.

SUPERVISORS (b) Social program; 150 students; voluntary general hospital, 500 beds; medical school affiliated; excellent salary; substantial increases; large city; midwest. (c) Neurological; teaching supervisor; general hospital, medical school affiliated; excellent salary; New York City. (d) Central supply; voluntary general hospital, 350 beds; \$300; large city; university medical center; California. (e) To coordinate central supply and surgery; voluntary general hospital, 300 beds; substantial salary; city 140,000, vicinity Chicago. (f) Clinical; 200 students; voluntary general hospital, 400 beds; about \$400; large city; university medical center; central. (g) Strictly administrative; medical-surgical wards; develop in-service program for professional and non-professional people; requires B.S. and experience in supervision; units of over 100 beds; voluntary general hospital, 500 beds; east. (h) Obstetrical; capable full charge de-

WOODWARD—Continued

partment covering 3 floors; modern air-conditioned unit; 400 deliveries per month; voluntary general hospital, 600 beds; large city; university medical center; south. (j) Operating room; reorganize, administer department and teach; important teaching hospital; \$4800; private room; attractive nurses home, \$20; large city; 2 medical schools; central. (n) Pediatric; active department of 50 beds; voluntary general hospital, 400 beds; requires B.S. and postgraduate work in pediatrics; \$350; opportunity continue studies; large city; midwest. (o) Psychiatric; new 50-bed unit; voluntary general hospital, 500 beds; medical school affiliated; to \$400; large city; midwest.

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BUSINESS MANAGER Middle west; 250-bed general hospital; require good experience as business manager in hospital of comparable size; this is a wonderful opportunity as hospital is growing rapidly and the future is there for the right person; \$6000 minimum to start.

(Continued on page 220)

SHAY—Continued

CLINICAL PSYCHOLOGIST — Will conduct psychological examining of patients; psychotherapy and research; also participate in the training of psychology interns; to \$5100.

DIETITIANS — (a) Chief; east; 150-bed general hospital, fully approved; all facilities complete and modern; \$4800 plus maintenance. (b) Assistant; east; 250-bed general hospital; serve approximately 220 patients; \$3600. (c) Chief; south; new ultramodern 70-bed hospital located in beautiful resort area; climate mild in winter; ideal in spring, summer and fall. (d) Assistant; east; 150-bed county hospital; no nursing school; supervise preparation of all foods for patients on special diets; \$3400 to start.

OCCUPATIONAL THERAPISTS — (a) Supervisor; head department of 600-bed teaching hospital; complete modern facilities; to \$4200. (b) Well known institution for care of neuro-psychiatric patients; occupational therapy program is one of most outstanding in the world; to \$4500.

PHARMACISTS — (a) Assistant; midwest; 250-bed general hospital, fully approved; 3 in department; to \$4500. (b) Northwest; 800-bed general hospital; 5 in department; \$350-\$400. (c) California; 200-bed general hospital; complete charge of department; \$5600. (d) Middle west; 325-bed hospital; 4 in department; beautifully located in residential section of the capital of the state; fishing and hunting abound; to \$4500.

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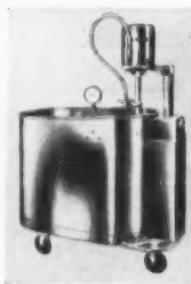
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**Currence, J. D., N. Y. State J. of Med. 48:2044, 1948.



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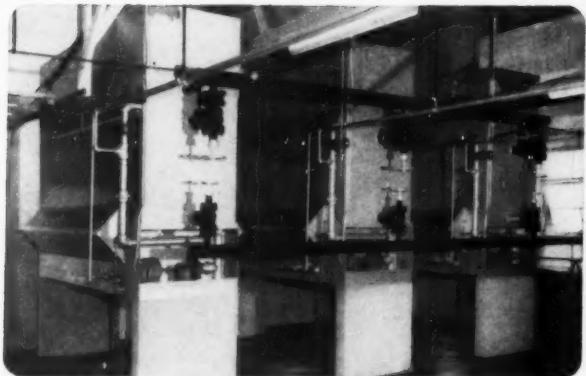
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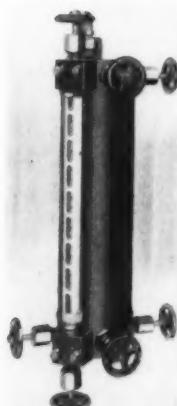
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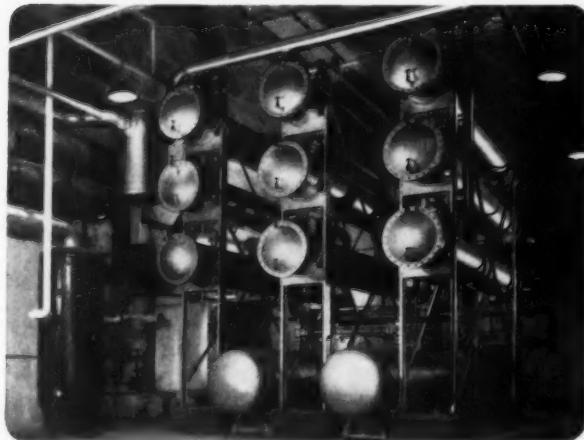
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SHAY—Continued

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NURSE ADMINISTRATORS—(a) 50-bed hospital, midwest. (b) Small New Jersey hospital. (c) Florida hospital. (d) 65-bed hospital for chronically ill; \$325, maintenance. (e) Orthopedic hospital, east.

DIRECTORS OF DIETETICS—(a) New 120-bed modern hospital; large university city. (b) 300-bed Ohio hospital.

INTERSTATE—Continued

EXECUTIVE HOUSEKEEPERS—(a) 175-bed Michigan hospital. (b) 200-bed hospital, southern college town. (c) 250-bed hospital, open fall; New England.

DIRECTORS OF NURSING SERVICE—(a) \$5000; 175-bed New England hospital. (b) 300-bed hospital, Pennsylvania. (c) New hospital, midwest.

PHARMACISTS—(a) 300-bed hospital, Pennsylvania. (b) Sisters' hospital, midwest; \$450.

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(Continued on page 222)



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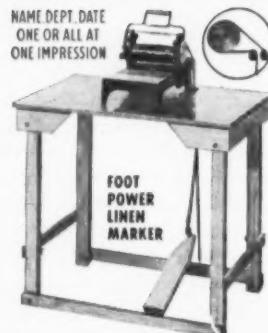
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(Continued on page 224)

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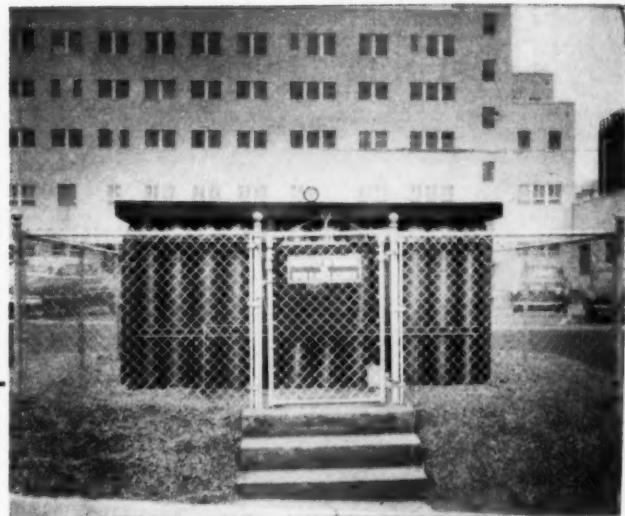
Trade-Mark

OXYGEN SUPPLY UNITS FOR PIPING INSTALLATIONS

Whether your hospital is small, medium, or large, an oxygen piping distribution system will enable you to administer oxygen more efficiently and economically. But, whatever the size, the first requirement is a dependable oxygen supply unit.

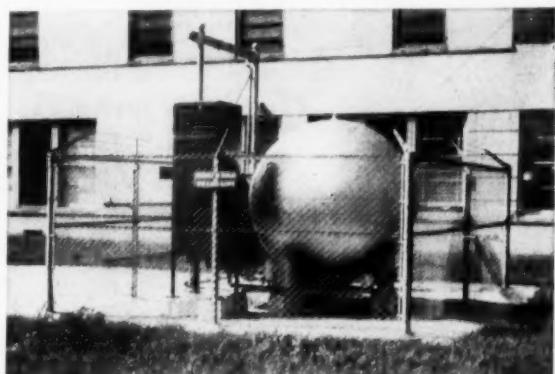
For small installations LINDE's cylinder manifolds, located within the hospital, are best for supplying the system. Manifolds accommodating any practical number of cylinders are available. For larger systems, LINDE CASCADE and DRIOX oxygen storage units are the most reliable means of providing an uninterrupted flow of oxygen to the pipe line. These units, which are loaned to the hospital, are installed on the hospital grounds. LINDE keeps them supplied with oxygen, delivered in liquid form by special trucks.

A background of pioneering work and long experience qualifies LINDE to help you and your architect work out the design, installation, and operation of an oxygen piping distribution system.



CASCADE oxygen storage unit

LINDE will be glad to survey your hospital for a piping system, work with your architects on the details of its design, and offer unbiased suggestions for the most effective type of pipe line equipment for your particular needs. For further information call or write your nearest LINDE office today.



DRIOX oxygen storage unit

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The terms "Cascade", "Driox", and "Linde" are registered trade-marks of Union Carbide and Carbon Corporation.

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For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of \$60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

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ADMINISTRATOR—Wanted for a new 84-bed hospital at Vandalia, Illinois, to be opened about August 1, 1954; salary to be decided; should have experience in equipping, staffing and organizing a new institution; should be prepared to assume duties on or about February 1, 1954. Write, MO 47, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—500-bed teaching hospital with an approved school for nurse anesthetists; school of nursing; intern and resident program; facilities include recovery room; 40-hour week; no call duty; paid vacation, sick leave, and holidays; retirement plan; discount privileges and other benefits; beginning monthly salary \$412; six-month raises. Write, Personnel Office, Hurley Hospital, Flint 2, Michigan.

NURSE—General duty; 500-bed teaching hospital, school of nursing, intern and resident program; paid vacation and sick leave; beginning monthly salary \$297; six-month increases; 5% afternoon and night shift premium. Write, Personnel Office, Hurley Hospital, Flint 2, Michigan.

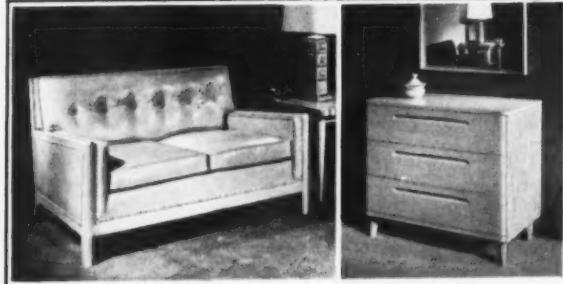


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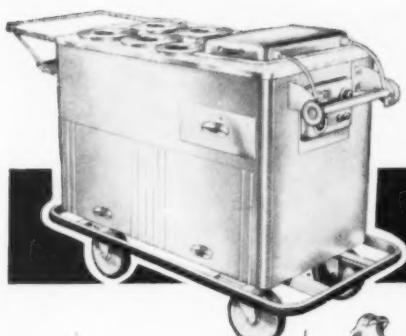
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With pride and satisfaction we announce the appointment of A. S. Aloe Company of St. Louis, Mo., as a distributor of Ideal Food Conveyors and all other hospital equipment items manufactured by The Swartzbaugh Manufacturing Company. A. S. Aloe Company will sell and service Ideal Conveyors and other Swartzbaugh specialized products throughout the entire United States.

Established in 1860, the A. S. Aloe Company long has specialized in bringing the best of hospital equipment quickly and economically to users everywhere. A trained, responsible Aloe representative is quickly available in any area, however remote. The addition of the great Aloe organization to already existing Ideal distribution means quick and competent sales and service everywhere in the nation, for Ideal Food Conveyors and the unique, specialized Swartzbaugh hospital products.



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What's New for Hospitals

AUGUST 1953

Edited by BESSIE COVERT

To HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 240. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Silent Mopmaster



A new line of equipment, known as the White Silent Cleaning Equipment, has been especially developed for use in hospitals and other institutions where quietness is essential. The Silent Oval Bucket is insulated against noise. It is equipped with a friction bail which is covered with a rubber grip at point of contact with bucket rim. The bucket base rim is completely fitted with a long wearing rubber guard.

The Silent Mopmaster outfit consists of two Silent Oval Buckets on a heavy steel truck mounted on 3 inch rubber casters. One bucket is designed for cleaning solution and the other has the sturdy "Can't Splash" Squeezer and contains rinse water. The cart handle is buffered with rubber to eliminate noise when slamming against the bucket and the corners of the cart have rubber bumpers. Silent operation is an added feature of this efficient double mopping outfit. **White Mop Wringer Co., Dept. MH, Fultonville, N. Y. (Key No. 66)**

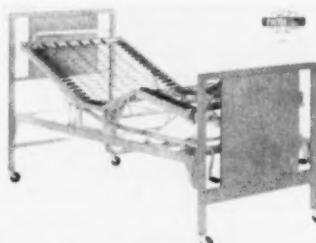
Orchard Nipple Cap

Orchard Nipple Caps for terminal sterilization of bottles of formula are now being made available direct to hospitals through the manufacturer. Perfected after five years of laboratory research, the nipple cap is made with a special waterproof glue that enables it to withstand terminal sterilization. It is made of fine, white kraft paper with a smooth, glazed finish on the inside so that the nipple cap slips on and off nur-

ing bottles easily. Space is provided for imprinting the date, name, nursery, formula and other information on the cap. The caps are easy to use and are packed 1000 in a handy dispenser box which can be hung on the wall or stored on a shelf. **Orchard Paper Co., Dept. MH, 3914 N. Union, St. Louis, Mo. (Key No. 67)**

Foster Bed Ends

Sturdy steel frame construction, modern design and functional efficiency are features of the new No. 972 Foster Bed Ends. A wide range of stock enamel and wood grain finishes is available or existing room furniture can be matched if desired. The modern design makes it easy to clean the new bed ends which, when combined with the Foster No. 7



Universal Gatch Spring, make a complete hospital bed unit. **Foster Bros. Mfg. Co., Dept. MH, 811 Broad St., Utica, N.Y. (Key No. 68)**

Mosaic Conductive Tile

A new Electrically Conductive Vitreous Ceramic Mosaic Floor Tile has been developed for use in hospitals. It is designed to protect against shock, arc or spark and is said to test within the resistance limitations of the National Fire Protection Association NFPA No. 56, "Recommended Safe Practice for Hospital Operating Rooms." The new tile dissipates static electricity, prevents accumulation of dangerous electrostatic charges and provides electrical conductivity between persons and equipment in contact with the floor. It also protects against electric shock hazard.

The new tile retains all qualities of

regular Ceramic Mosaic Floor Tile. It is durable, sanitary and easy to clean with any type of detergent. It is available in a neutral brown and is an unglazed, dust-pressed, porcelain type Ceramic Mosaic Floor Tile with square edge. **The Mosaic Tile Co., Dept. MH, Zanesville, Ohio. (Key No. 69)**

Bedside Cabinet

A feature of the new Royal Metal Bedside Cabinet is the reversible door. The door can be changed to hang from either left or right side of the cabinet, depending upon its location beside the patient's bed. It is easily changed by unfastening the concealed hinges, turning the door upside down and fastening the hinges in the holes already made in the opposite front side of the cabinet interior. Another double set of perforations in the cabinet frame allows reversing the noiseless door catch.

The cabinet has a single top drawer and large storage area. It is made of extra heavy metal with soundproofed inside construction. The top may be either one piece all-welded metal or self-banded Formica, both of which are easy to clean, are cigarette and alcohol proof and resistant to mild acids and most medicines. The top is removable and replaceable and the complete top and lower section can be removed for easy refinishing.



ing. The cabinet is available in a variety of Plastelle baked enamel finishes. **Royal Metal Mfg. Co., Dept. MH, 175 N. Michigan Ave., Chicago 1. (Key No. 70)**

What's New...

High Temperature Paper Tape



A new high temperature tape has been introduced by Seamless Rubber for many hospital uses. It is particularly well adapted to preparing autoclave bundles as a replacement for folding, pinning and tying techniques. The tape sticks quickly, seals fast, removes cleanly and can be marked by pencil, pen or crayon for quick and lasting identification during sterilization. It is available in $\frac{1}{2}$, $\frac{3}{4}$, 1 and $1\frac{1}{2}$ inch widths in 60 yard rolls. **The Seamless Rubber Co., Surgical Dressing Div., Dept. MH, New Haven 3, Conn.** (Key No. 71)

Kenflex Vinyl Tile

Kenflex is a new multi-purpose vinyl asbestos tile which is greaseproof, alkali-proof, fire resistant and resistant to acids, cooking fats, oils and gasoline. It is easy to install, being laid tile by tile, and can be safely installed on concrete in direct contact with the earth. It can be assembled in any desired patterns and is available in fourteen colors. Since the colors go all the way through the tile, they do not fade or wear off.

The tile is strong, tough and flexible, is made to withstand heavy traffic and to resist indentations. It comes in 9 inch square tiles and in feature strip as well as Flexobase, to be applied where wall meets floor to seal off the joint. **Kentile, Inc., Dept. MH, 72 Second Ave., Brooklyn 15, N. Y.** (Key No. 72)

Wireless Intercom

The Bogen model TWIN wireless communophone system is simple to install and can be used with two or more stations, all conversation being heard by all stations in the system. In most cases, a station can be located wherever there is a power outlet and readily moved from place to place as needed. The system employs the power lines already existing in a building as the transmitting medium and an exclusive line noise suppression circuit in every unit. Each station contains a transmitter and receiver.

The Bogen "Silent Watchman" permits a station to be locked in "transmit" position for use in various applications where a continuous listening arrangement or aural supervision is desired. The stations are placed in service by

simply plugging into the outlet. Additional stations can be added to the system at any time. **David Bogen Co., Inc., Dept. MH, 29 Ninth Ave., New York 14.** (Key No. 73)

X-Ray Film Hanger

A new x-ray film hanger has been announced which is of stainless steel construction throughout to withstand the corrosive effects of the solutions used in processing exposed x-ray film. Also new is a semi-automatic loader board which punches the film and guides the hanger to pick up the film. Hangers are narrow enough to fit either hand or fully automatic processing tanks, permitting resumption of developing in hand tanks in the event of machine failure. The method of loading simplifies and expedites that procedure and ensures equal fastening of the film and instant removal.

The hanger and loader permit fast, positive fastening of exposed x-ray film in total darkness without previous experience. The board is designed to be mounted on the wall or a narrow shelf, thus saving floor space. The hanger and



loader illustrated are for 14 by 17 inch x-ray film but other models are available for other sizes. Punches and dies are fully adjustable and easily removable. **Hard and Co., Inc., Dept. MH, 709 Main St., Ann Arbor, Mich.** (Key No. 74)

Sandwich Unit

A small, low-priced sandwich unit has been introduced for use in small lunch rooms, tea rooms and fountains. The Serv-All Sandwich Unit fits into any standard ice cream cabinet yet provides complete facilities for serving all kinds of cold meat and salad sandwiches. Four containers covered by two double lids for sandwich spreads or pickles, a storage rack for sliced meats and cheeses and a sectional type maple cutting board are included in the compact unit. **Smith Werner Co., Dept MH, 610 Santa Fe Drive, Denver, Colo.** (Key No. 75)

Roof Drain

The new Zurn Air Relieved Cloudburst Type Roof Drain has been developed to relieve the possibility of damage to roof areas by heavy loads of backed-up water. The new drains have an especially large and deep sump area

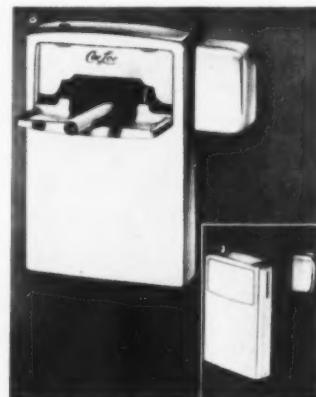
which acts as a temporary reservoir, allowing entrained air to escape before water enters the drain pipe. Extra large, non-clogging mushroom type dome strainer increases the free open area of straining surfaces. The dome has a wide flair to permit maximum flow into the drain. A gravel guard prevents clogging of primary drainage and the locking device to secure dome to body makes it easily released for cleaning. **J. A. Zurn Mfg. Co., Dept. MH, Erie, Pa.** (Key No. 76)

Decorative Floor Coating

Colorflex Plus AWA is a decorative and protective floor coating designed for use in laundries, engine rooms, washrooms, offices, kitchens and other areas requiring special protective coating on floors. It is not affected by fruit, vegetable or lactic acid and cannot be softened by water, mineral oils or grease, according to the manufacturer. Its penetrating synthetic resin base makes it effective for painting concrete and it seals and colors wood, brick, composition and other surfaces. **Flexrock Co., Dept. MH, 3657 Filbert St., Philadelphia 1, Pa.** (Key No. 77)

Combination Door Lock

A dual purpose combination self-cleaning ashtray and toilet stall door lock is being introduced as the Cee-Loc. It ensures privacy, locking at the touch of a button, and provides a clean place to lay a cigarette. The cigarette shelf is automatically brought into position for use when the stall door is locked. The door is unlocked by lifting the cigarette shelf, and at the same time the ashes are emptied into a fully concealed self-contained receptacle. The receptacle is quickly and easily removed for emptying through use of a special key. **Cee-Loc**



is practically theftproof and is easily installed. **The Electric-Aire Engineering Corp., Cee-Loc Div., Dept. MH, 209 W. Jackson Blvd., Chicago 6.** (Key No. 78)

WHY BUY 3 to 5 CANS

**when
only
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will
do?**

No—a WITT CAN won't hold more than any other Can of equal capacity. However—WITT CANS are *guaranteed to outlast 3 to 5 ordinary Cans.* Here's an offer of reduced purchases and dollar savings worth investigating. Perhaps you're wondering why WITT CANS last so long. Here are just a few reasons:

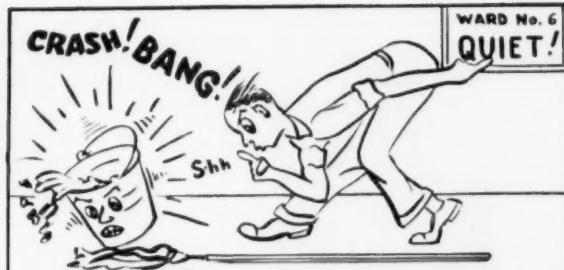
- STRAIGHT SIDES**—assure extra resistance to rough handling.
- DEEP ROLLING CORRUGATIONS**—run full length of Can, adding further rigidity.
- HEAVY GAUGE STEEL**—provides battleship ruggedness.
- STRUCTURAL STEEL BANDS**—protect top and bottom of Can and act as shock absorbers.
- HOT DIP GALVANIZING**—a hand process after fabrication, insuring heaviest possible rustproofing.
- PINCH-PROOF HANDLES**—for easy handling.
- STURDY LID**—snug fitting, yet easy to remove.

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DIRTY CLEAN THOSE FLOORS *Silently*

WITH **WHITE** SILENT
MOPPING EQUIPMENT



SILENT OVAL BUCKET

White Silent Cleaning Equipment is especially made for use in hospitals and institutions where quietness is essential. The Silent Oval Bucket illustrated is fully insulated against noise by use of rubber at all points of metal to metal contacts.



SILENT ROL'OWL

The famous White Rol'owl Mop Wringer is insulated throughout against noise in operation. Equipped with rubber rollers.



SILENT MOPMASTER

The most efficient Double Mopping Outfit made with the added features of silent operation. Two Silent Oval Buckets—one for cleaning solution and one for rinse water and the "Can't Splash" Squeezer combined with a sturdy rubber protected steel truck that moves quietly and easily.

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SAYS
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A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

What's New . . .

Square-Pak Flasks



American Square-Pak Flasks have rounded corners for easy cleaning but are square for maximum content in minimum storage space. With the A.S.P.F. automatic sealing closures, a maximum number of the flasks can be sterilized in each load because of the space saving design. The flasks are relatively inexpensive and are available in 75, 150, 500, 1000, 1500 and 2000 ml. sizes.

The A.S.P.F. automatic sealing closure eliminates manual operation. The Auto-Seal and Auto-Pour Collars are made of Neoprene to withstand hundreds of sterilization periods, the Auto-Cap is made of heavy bakelite for long

life and the unit assures accurate sealing. **American Sterilizer Co., Dept. MH, Erie, Pa. (Key No. 79)**

Universal Baseboard

The completely redesigned line of Kritzer Baseboard Heating equipment includes models to meet every requirement for institutional or industrial heating, either steam or hot water. A feature of the line is the full height, solid steel back plate which aligns the entire baseboard assembly, firmly supports all elements, and acts as a barrier against loss of heated air into walls while protecting wall surfaces from dust streaks. The new Kritzer slide cradle fits snugly to the fins and prevents movement of the coil unless necessary for realignment. The enclosure is easily assembled or removed for cleaning. **Kritzer Radiant Coils, Inc., Dept. MH, 2901 Lawrence Ave., Chicago 25. (Key No. 80)**

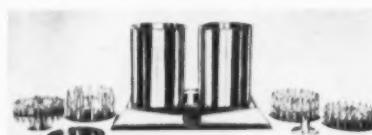
Ajax Cleaner in Paste Form

Developed for institutional and commercial use, Ajax Paste Cleaner is designed for any maintenance cleaning program. It cuts grease quickly and is recommended for cleaning surfaces such as tile, aluminum, glass, brass, enamel, rubber, marble, earthenware and others.

The Ajax "foaming action" polishes as it cleans. The new product is available in 300 pound drums and 50 pound pails. **Colgate-Palmolive-Peet Co., Dept. MH, 105 Hudson St., Jersey City 2, N. J. (Key No. 81)**

Buechel Syringe Cleaner

A new cleaner has been developed by a nurse for easy and efficient cleaning of syringes, preparatory to autoclaving. Handling and breakage are reduced with the Buechel Syringe Cleaner which is easy to operate, has nothing mechanical and is designed for years of use. Syringes are matched in the rack, thus saving time of matching after cleaning. Syringes are agitated in a detergent solution, then rinsed, the time of cleaning depending upon the condition of the syringes. The



cleaner has stainless steel base with timers, stainless steel racks and containers and a holder of polished aluminum. **Buechel Products Co., Dept. MH, Foulke Station, Box 61, Richmond, Ind. (Key No. 82)**

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ICE CART*

MODEL XV
150 lb. capacity

**GENNETT
AND SONS, INC.
Richmond, Ind.**

Right . . . the Model XV is the answer! Stainless Steel construction throughout, for DURABILITY. Three-inch thick insulation keeps your profits from melting away. Made in 3 sizes—50, 75 and 150-lb. capacities. Keep pace with the well-equipped institution . . . Go Gennett!

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Colorful and gay, simple or dignified, they're charming mealtime highlights . . . make good food more enticing, more enjoyable. All popular sizes.

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What's New . . .

Rescue Ambulance

Two new ambulances have been introduced for rescue work. The Superior-Cadillac Rescuer and Super-Rescuer have been specially built to meet the extra requirements for this type of work. They are four-patient units with extra storage space for first aid and emergency equipment, extra warning lights, extra assist rails and additional safety and convenience features for both patients and attendants.

The interior space has fourteen large compartments with 24 cubic feet of storage space, including an oversize compartment in the squad bench for oxygen equipment. The headroom of 48 inches in the Rescuer and 52 inches in the Super-Rescuer provides ample space for



transporting cardiac patients in a sitting position on routine runs or using hanging stretchers to transport patients on rescue runs. The new Superior-Cadillac units are built on the 1953 commercial Cadillac chassis designed specifically for ambulance operation. Safe-T-Bar door

locks and a foolproof hook-and-claw combination on the rear side doors prevent accidental opening of doors. Superior Coach Corp., Dept. MH, Lima, Ohio. (Key No. 83)

hot or cold liquids in quantity. It has a capacity of five gallons and can be used with food conveyors for carrying bever-



Penn-Drake Washoil

Developed specifically for institutional laundries, Penn-Drake Washoil produces softer linens, reduces washing and extracting time and prevents "stogies" or "whips" from forming around the rolls of the flatwork ironer. It is impregnated into the linens after the final rinse and allows reduction in customary operating procedures, including shorter washing, extracting and drying time. The resulting softness of linens helps to overcome diaper rash and bed sores.

The use of Penn-Drake Washoil also reduces lint and fire hazard and eliminates static from all materials, including nylon. A germicide in Washoil removes odors by killing bacteria. Linen service is increased through use of the product, according to the manufacturer. Pennsylvania Refining Co., Dept. MH, Butler, Pa. (Key No. 84)

ages, for between meal nourishment and in cafeterias, lunch rooms, floor kitchens or nurses' homes.

The jug has a strong electrically welded stainless steel lining inside a rolled steel shell with aluminum color finish. The wide mouth permits ease of cleaning and a heavy rubber gasket holds the cover rigidly in place. Non-corrosive metal is used for the quick flow safety lock spigot and an adjustable plastic push button control ring prevents accidental release or loss of contents. Landers, Frary & Clark, Dept. MH, New Britain, Conn. (Key No. 85)

Stanley Banquet Jug

The new Stanley unbreakable Banquet Jug ST3304 is designed for transporting

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Seconds instead of minutes save many lives

When loved ones must be hospitalized, the family rests more easily when POTTER SLIDE TYPE ESCAPES stand guard, ready to receive and slide patients, nurses and interns safely to the outside ground and helpful hands, in seconds instead of minutes.

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Inside stairways have always been crushing death traps from stampedes.

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For a quarter century our campaigns have succeeded not only financially, but in the excellent public relations we have established for our clients.

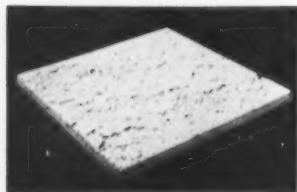
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& ASSOCIATES

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What's New . . .

Fissured Tile



Incombustible Fissured Tile has been added to the Simpson line of acoustical products. The fissured tile is manufactured from a special type of rock that is melted and re-formed into a highly absorbent rock wool. The manufacturing process results in a natural formation of fissures offering high sound absorption efficiency. The tile is produced in 11/16 and 13/16 inch thicknesses with either square or beveled edges. The tile has a white finish for high light reflection, but may be repainted without loss of acoustical efficiency. **Simpson Logging Co., Dept. MH, 1065 Stuart Bldg., Seattle 1, Wash.** (Key No. 86)

Anti-Slip Wax

Triple Service Floor Wax is designed to give good service in all respects for low cost floor care. It is listed as a highly anti-slip material by Underwriters' Laboratories, according to the

manufacturer, and is not tacky or gummy, has unusual self-leveling qualities and dries in less than 20 minutes to a brilliant transparent shine. The wax is water resistant within one hour after application and yet is easy to remove when desired. It resists repeated damp moppings and may be spot cleaned and spot waxed without showing overlap marks. **R. M. Hollingshead Corp., Dept. MH, 840 Cooper St., Camden 2, N. J.** (Key No. 87)

The electric cord is simply plugged into any standard circuit. Safety features prevent a door from opening when anyone is standing on the opposite side of the doorway. In case of power failure the door can be operated manually without locking or jamming. **Dor-O-Matic Division of Republic Industries, Inc., Dept. MH, 4446 N. Knox Ave., Chicago 30.** (Key No. 88)

Automatic Door Control

A newly designed, electrically operated hydraulic door control has been introduced. Known as the "Invisible Dor-Man" the unit opens any type of door automatically through a control mechanism concealed in the floor. Concealed under a carpet leading through the doorway, the mechanism opens the door as soon as one steps on the carpet. The door remains open until the person has walked through, then closes with a two-speed action. The initial closing speed is greatly reduced during the last few inches of closing to assure noiseless operation. Speeds can be adjusted at time of installation.

The unit is easily installed and maintained and is economical in price. The hydraulic power unit can be hidden from view at any distance from the door.

Laureline Tumbler



Unusually resistant to chipping, cracking and breaking, Laureline Tumblers are made of clear or colored plastic. The new tumblers have been molded into a graceful, curved shape, comfortable to hold and easy to stack. They are firm, not pliable, and normal dishwashing temperatures do not affect their form or

AT LAST! *Dexter Diapers*

The diaper that does away with half the work in your laundry and nursery.

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Dexter Diapers eliminate all folding in your laundry and nursery.

SPECIAL LOW PRICE TO HOSPITALS
Write direct to manufacturer or ask your favorite diaper service.

Most popular diaper used today in hospitals over the nation . . . from local diaper services or in their own laundry.

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IDEAL BABY SHOWER GIFT
We Less Money On This Offer



For "Modified Diets" or Regular Feeding

YOU can prepare your patients' meals with more efficiency and less cost. That important expense may be cut considerably without impairing calorie-content. The preparation and serving of foods may be handled quicker, more thoroughly and with less lost motion by using DON—

EQUIPMENT • FURNISHINGS • SUPPLIES

Even a general or "special diet" kitchen may be obsolete or antiquated and may need modernizing. Dish washers, food mixers, apple parers, potato peelers, food carts and other equipment will save time. These and others of the 50,000 items you may need are sold by DON. Every item sold on a guarantee of satisfaction or money back.

Write Dept. 14 for a DON salesman to call
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EDWARD DON & COMPANY
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What's New . . .

surface gleam. They are available in 9½ ounce and 5½ ounce sizes and in translucent Raspberry, Lemon and Mint colors in addition to Ice, which is clear and colorless. **Boonton Molding Co., Dept. MH, Boonton, N. J.** (Key No. 89)

Drainage Bottle Rack

A simple device is available to take care of the troublesome problem of the drainage bottle beside the patient's bed.



Known as the Adelco Drainage Bottle Rack, it simply hangs over the bed rail and holds the drainage bottle securely and safely out of the way. The sturdy constructed unit is finished in aluminum paint and the recessed design keeps the bottle out of the way when changing linens or cleaning floors. It is not in

the way for nurse or visitor and helps to prevent accidental pulling of catheter from wound. **Adelphi Surgical Co., Dept. MH, 632 Fulton St., Brooklyn 17, N. Y.** (Key No. 90)

Dynel-Blend Blanket

A new Dynel-Rayon Blend blanket has been introduced. Features of the new blanket include low shrinkage, excellent warmth, good shape retention, color fastness, long wear and a complete lack of electrostatic properties. It is available in bright clear colors, including Casino Red, Hunter Green, maize, rose, chartreuse and blue. **Pepperell Mfg. Co., Dept. MH, 160 State St., Boston 2, Mass.** (Key No. 91)

Medicine Cart

All stainless steel construction is used in the new Steri-Cart for dispensing oral and hypodermic medications. The cart is so designed that one nurse can prepare and administer medication for a nursing section up to 50 patients, 30 oral and 20 hypodermic. The cart is designed so that there is space for all equipment and supplies needed.

The top section of the Steri-Cart holds 30 one ounce medicine glasses with name card holders. The card holders show the

cards at a 45 degree angle for easy reading. An automatic alcohol dispenser, a two quart stainless steel covered pitcher



and a stainless steel covered instrument tray are held firmly by Hasco Clips to eliminate noise. Syringe carriers are built in the drawers which can be removed for sterilization. The cart may be purchased with or without the drawers, or drawers may be supplied without syringe carriers for general storage of supplies. The cart is 20 inches wide, permitting easy movement between beds. It is equipped with 4 inch ball bearing rubber tired casters and has rubber cushioned bumpers. **Harold Supply Corp., Dept. MH, 100 Fifth Ave., New York 11.** (Key No. 92)

Is Your Food Service Threatened With DODO-ITIS?

Meals-On-Wheels makes floor-kitchens extinct . . . banishes forever the threat of inadequate food service. You gain valuable bed or office space . . . speed service . . . centralize preparation, portioning, dietetic supervision and training. Model 18-D (below)—using standard dinnerware and trays—delivers 18 appetizing, temperature-right meals (at less than 1 minute per patient.)



* The DODO BIRD—*Didus Ineptus*
Progress passed him by.



Meals-on-Wheels

See M-O-W Exhibit at A.D.A. Conv., Aug. 25 to 27; A.H.A. Conv., Aug. 31 to Sept. 3

— WRITE FOR INFORMATION → **CRIMSCO, INC.**
1734 OAK — KANSAS CITY, MO.

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When fire occurs you must be able to prove what you lost and its cash value.

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What's New . . .

Transcopy Duplex



Only one machine is required to make photocopies in less than a minute with the Transcopy Duplex. Developing, washing, fixing or drying are all done in the one machine which makes finished, photo-exact, positive copies of any record, regardless of type or color, from originals up to 14½ inches wide in any length. The single machine contains both a printer and a processor. It is small, light and compact and takes up a minimum of space. No special installation is required as the machine operates by being plugged into any electrical outlet. No darkroom is needed. Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 93)

Aluminum Frame Folding Chairs

Beauty, comfort and strength are combined with extremely light weight in the new Lyon aluminum frame folding chairs. The chairs fold flat for compact storage, are comfortable in design and sturdy. Steel seats and backs are finished in baked-on enamel, in either walnut or taupe. The aluminum frame has a clear varnish finish. The chair is available in three models: aluminum frame with steel seat and back, with cane steel seat and back, and with pressed wood seat over steel and steel back. Lyon Metal Products, Inc., Dept. MH, Aurora, Ill. (Key No. 94)

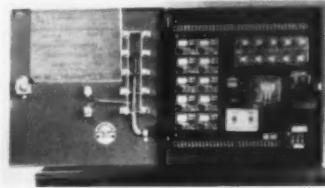
Fire Detection Control Panel

A new fire detection control panel is being introduced. The panel is composed of two series of super-sensitive relays, wired in balance to give a completely supervised, closed circuit Fire Alarm System. It operates from standard A.C. outlets. In case of power failure a selector relay automatically puts the system onto standby batteries. In case of circuit breakage anywhere throughout the installation, both audible and visual indication is given.

The Control Panel has Underwriters Laboratories approval, according to the manufacturer. It is sturdily constructed for trouble-free operation and is designed to be foolproof. Alarm systems are maintained automatically by the control unit until reset. Indicator lights on the panel

Airfoil Fan

A new design in fans for all heating, ventilating and air conditioning systems is offered in the new Chicago Airfoil Centrifugal Fan, Type A. The wheel is of the backward curve type with airfoil hollow sectioned blades. The blades conform to the aerodynamic principles used on modern aircraft to produce the greatest volume and the smoothest flow of air possible. The airfoil wheel operates quietly and both wheel and housing are of all-welded heavy gauge steel plate construction. Chicago Blower Corp., Dept. MH, 9869 Pacific Ave., Franklin Park, Ill. (Key No. 95)



give visual location of the fire or trouble area. Notifier Manufacturing Co., Dept. MH, 239 S. 11th St., Lincoln 8, Neb. (Key No. 96)

Two New PUTNAM Books for the Hospital Administration and Staff Members

PRINCIPLES OF HOSPITAL ADMINISTRATION

by John R. McGibony, M.D.

Brings together in concise form the best of administrative planning to serve the busy executive and members of his staff.

THIS HOSPITAL BUSINESS OF OURS

by Raymond P. Sloan

Foreword by George Bugbee

A book every board member should have immediately, since the author has specifically pointed out the trustee's authority. Be sure the members of your board are supplied with it at once.

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The name "Berbecker" in surgical needles means good functional design—uniform resiliency—and long service life. (Sold only through dealers.)

BERBECKER SURGEONS' NEEDLES

Made in England for the Surgeons and Hospitals of America

Julius Berbecker & Sons, Inc., 15 E. 26th St., New York 10

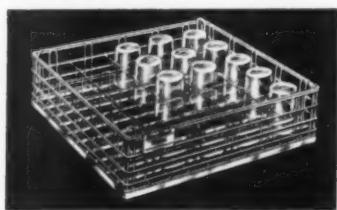
What's New ...

Catheter Gauge

An accurate means for measuring catheter sizes from 1 to 34 French is offered in the new A.C.M.I. Plastic Catheter Gauge. Color code, which conforms to bandings on the ureteral catheters from 4 to 8 French, is stamped on the front side. A millimeter scale is provided for ready reference. The reverse side is used to provide useful information on A.C.M.I. lamps and cutting loops. American Cystoscope Makers, Inc., Dept. MH, 1241 Lafayette Ave., New York 59. (Key No. 97)

Glass Rack

A new 36 compartment Sani-Stack glass rack is now available with individual welded cells for each glass. It pro-



vides protection against scratching and "frosting" which occur when glasses come in contact with each other, and is designed for use in transporting, wash-

ing and storing glasses. The racks can be stacked for easy and convenient storage of glasses and for placing on trucks and dollies for moving glasses to and from storage cupboards. The racks are made of low carbon bright basic steel dipped in molten tin after fabrication. They can be obtained in all sizes for every type glass and every model dish-washing machine. Metropolitan Wire Goods Corp., Dept. MH, 70 Washington St., Brooklyn 1, N. Y. (Key No. 98)

Chair Caddy

A complete line of chair and table handling equipment has been introduced. The new Chair Caddy 60 is designed to handle up to 60 single fold or 30 double folding chairs of any size. It is constructed of heavy gauge steel with all joints spot welded to ensure long life and trouble free operation. The extra heavy duty ball bearing casters are designed to assure easy wheeling even with a full load.

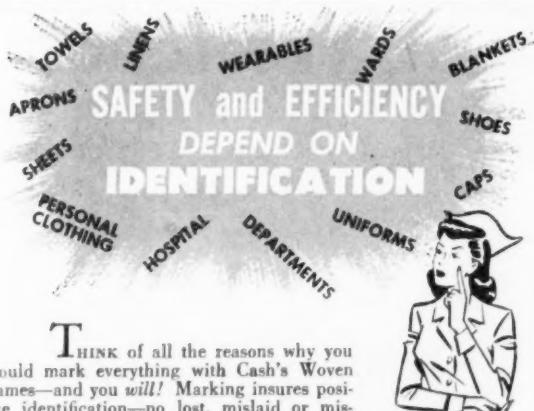
Other items in the handling equipment line include an adjustable chair caddy, an understage model and a Folding Table Caddy designed to handle any size tables from 30 by 60 inches to 36 by 96 inches. The equipment is ruggedly constructed for long hard use. Midwest Folding Products, Dept. MH, Roselle, Ill. (Key No. 99)

"Pebble Ice" Maker



The new Ajax "Pebble Ice" Maker produces quantities of small, dry ice pellets similar to crushed ice. It is a small, cabinet unit taking less than one square yard of floor space, and 39 inches in height, suitable for counter installation. The machine is simple, with only three moving parts, and is available in three capacities: 200, 400 or 800 pounds of ice per day.

The unit has an automatic shut off switch which controls ice overflow, no matter what type of storage container is used. Ajax Corp. of America, Dept. MH, 2509 Washington Ave., Evansville, Ind. (Key No. 100)



THINK of all the reasons why you should mark everything with Cash's Woven Names—and you will! Marking insures positive identification—no lost, mislaid or misused linen or clothing; the right thing in the right place; fewer arguments; less danger of contamination; protection for patients, nurses, doctors, hospitals; greater efficiency and economy. The name of hospital or personal owner woven into a Cash's Name Tape guards your belongings permanently.

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For today's BUSY physician—
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in the treatment of burns, minor
wounds, abrasions in office,
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What's New . . .

Time-Saving Imprinter

Considerable time of nursing personnel can be saved when the new Model 11-3 Imprinter is used at the nursing station or business office. Each patient



has a plate embossed with name, room number and other information and the Imprinter has a built-in rotary dater. When forms are needed the nurse merely picks the plate required from the visible desk file, inserts it in the Addressograph-Multigraph nursing station Imprinter, inserts the form and with one stroke of the machine all of the information is stamped on as many copies as are required.

The Model 11-3 Imprinter is simple in operation and eliminates tedious writing of basic information on forms, as well as the possibility of errors. **Addressograph-Multigraph Corp., Dept. MH, 1200 Babbitt Rd., Cleveland 17, Ohio.** (Key No. 101)

Needle Washers

The Kleen-O-Matic needle washer and rinser has been improved so that it will now clean all types and sizes of hypodermic needles. Needles are placed in a specially designed manifold which is inserted in the Kleen-O-Matic Washer for 30 seconds, then transferred to the Rinser for 30 seconds. Clean needles are emptied onto an inspection tray from which they are easily loaded into needle holders for autoclaving.

The manifold is designed to ensure thorough washing and rinsing of all parts of the needle. The method of washing is such that needle points remain sharp as they are not vibrated against a stream of solution. **Macalaster Bicknell Parenteral Corp., Dept. MH, 243 Broadway, Cambridge 39, Mass.** (Key No. 102)

Circumcision Clamp

A new stainless steel instrument for infant circumcision has been developed by Dr. Herman I. Kantor of the Southwestern Medical School, University of Texas. The Kantor Circumcision Clamp has a flat upper surface to facilitate cutting of the foreskin. The hemostat effects a thin line along its crushing surfaces, the jaws permit equal firm pressure along this line and a tooth at the tip of the clamp prevents side slipping.

J. Sklar Mfg. Co., Dept. MH, 38-04 Woodside Ave., Long Island City 4, N. Y. (Key No. 103)

Call Button Holder

A simple device for holding the nurses' call button on the side of the bed in easy reach of the patient is now available. It slips on standard bed rails in any convenient position, eliminating the possibility of damage to linens when the button is fastened by pins. It keeps the cord off the bed while holding the button in an upright position for the patient's convenience. The device is easily



installed without tools and need not be removed when bed linen is changed. **Kadette Products Co., Dept. MH, 1360 W. Touhy Ave., Chicago 26.** (Key No. 104)

For Years
Hospitals Have Used
DISPOSABLE
QUICAPS
NURSING BOTTLE
CLOSURES

Write for complimentary package of professional samples. The Quicap Co., Inc., 110 N. Markley Street, Dept. H, Greenville, S. C.

PROJECTING

"OVER THE DOOR"
ROOM NUMBERS
... now solve your
open door problem.



Plastic number plates, projecting over the doors of hospital rooms also make it easier to find the rooms without confusion or delay because the numbers are clearly visible for considerable distances down the hall. Actual size of number plate is 2" x 5" with large, bold 1½" high white numbers on both sides with a choice of colored backgrounds. Also available in flat door plate style.

**PLASTIC TAG AND TRADE CHECK CO.
BAY CITY 5, MICHIGAN**

ORDER
FROM YOUR
DEALER OF
HOSPITAL
SUPPLIES
OR WRITE
FACTORY
FOR COMPLETE
DETAILS.

51

What's New . . .

Pharmaceuticals

New Form for Capsules

To identify Lilly products, most of the pulvule specialties and all of the Enseals (Timed Disintegrating Tablets, Lilly) are now being made available in new forms. Lilly pulvules have a new parabolic end which gives them a bullet-shaped appearance. Lilly Enseals have had tiny, brilliantly colored flecks of gelatin incorporated in the medicament as an identifying feature. Eli Lilly & Company, Dept. MH, Indianapolis 6, Ind. (Key No. 105)

Streptohydrazid

Streptohydrazid is a streptomycinisoniazid crystalline chemical compound indicated in the treatment of almost all types of tuberculosis. It is designed for one-a-day injection, thus minimizing discomfort to the patient and simplifying the work of nurses and doctors. The product is said to offer enhanced therapeutic action, delayed emergence of resistant strains and minimal incidence of hearing loss. Each single-dose vial contains 1 Gm. of streptomycin combined with 236 mg. of isoniazid. Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing Ave., Brooklyn 6, N. Y. (Key No. 106)

Deltamide

Deltamide is a mixture of four sulfonamides including sulfadiazine, sulfamerazine, sulfamethazine and sulfacetamide. By combining four of the sulfonamides, the product provides rapid initial absorption and effective blood levels with high urinary solubility and low toxicity. It is supplied in chocolate-flavored suspension and in tablet form. The Armour Laboratories, Dept. MH, 520 N. Michigan Ave., Chicago 11. (Key No. 107)

Gantrisin Diethanolamine

Gantrisin Diethanolamine Ear Solution 'Roche' is a stable, sterile, antibacterial solution for the treatment of ear infections. It provides local antibacterial action, promotion of healing and relief of pain. It is useful in the treatment of ear infections and for prophylactic use following surgery. It is supplied in $\frac{1}{2}$ ounce vials with dropper. Hoffmann-La Roche Inc., Dept. MH, Nutley 10, N. J. (Key No. 108)

White's Appliderm

A new line of therapeutically rational, purposefully simple dermatologic preparations is being offered under the trade

name of Appliderm. The six ointments and one lotion were developed as a result of years of clinical trial and investigation by the Department of Dermatology of Harvard Medical School and Massachusetts General Hospital. Appliderm is designed to alleviate symptoms and to avoid complications of "overtreatment dermatitis" in skin disorders. Appliderm is available in an antipruritic lotion, an antipruritic ointment, an emollient ointment, a resorcinol-sulphur ointment, a sulphur-salicylic ointment, a tar ointment and an undecylenic acid ointment. White Laboratories, Inc., Dept. MH, Kenilworth, N. J. (Key No. 109)

Erythromycin Tablets

Erythromycin Tablets are indicated in the treatment of pneumococcal, staphylococcal and streptococcal infections, particularly in patients who are sensitive to other antibiotics and in infections in which the causative organisms are resistant to other antibiotics. Each peach colored, protection coated tablet contains 100 mg. of Erythromycin. The coating preserves the contents from the inactivating effects of gastric acidity and permits prompt absorption of the antibiotic in the small intestine. Erythromycin is supplied in bottles of 25 tablets. The Upjohn Company, Dept. MH, Kalamazoo, Mich. (Key No. 110)

OUTSTANDING

GENERAL HOSPITAL MATTRESSES

REST-RITE has developed a completely new kind of inner-spring General Hospital Mattress which saves an average of 75% of your investment during 10 years. The miracle "Syko" covering used on these mattresses makes possible this great economy. Made in all sizes.

Rubber sheets and plastic covers are not needed because this material is impervious to body fluids and wastes—easily cleaned with soap and water for immediate re-use. Non-irritating to the skin—almost indestructible, fire resistant. Cotton sheets stay smooth. Patients report "more comfortable than other mattresses."

For complete information, sample of the super-tough "Syko" covering, and SPECIAL INTRODUCTORY OFFER, write today to—

THE REST-RITE BEDDING CO.
Mattresses since 1898
207 North Main St., Mansfield, Ohio

Sleeping Luxury—At Lowest Cost Per Year of Service!



Time and again, St. Marys blankets have proved their remarkable economy through the long years of service they render. Soft, luxurious, beautiful—they add to your reputation for thoughtful service. St. Marys blankets are certified washable by the American Institute of Laundering. Available in standard contract styles and also with special bindings, stamped or custom-designed monograms.

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ST. MARYS BLANKETS • ST. MARYS, OHIO

"They last . . . and last . . . and last"

What's New . . .

Aludrox

Aludrox, Aluminum hydroxide gel with magnesium hydroxide, is a pleasantly flavored antacid in suspension and tablet form. It is designed to control temporary gastric hyperacidity and to relieve the pain associated with hyperacidity in peptic ulcer and in the medical management of ulcer. Suspension Aludrox is supplied in bottles of 12 fluid ounces, Tablets Aludrox in boxes of 60 tablets. Wyeth, Inc., Dept. MH, 1401 Walnut St., Philadelphia 2, Pa. (Key No. 111)

Alevaire

Alevaire is a new detergent inhalant with sputum-liquefying action. It is administered by means of any standard aerosol or nebulizer technic. It is an outgrowth of aerosol studies conducted on tuberculous patients. It has also proved effective in the treatment of chronic pulmonary diseases characterized by highly viscid mucous and has been used instead of humidifying procedures in the treatment of such childhood diseases as laryngitis and acute tracheobronchitis. In neonatal asphyxia due to inhalation of amniotic fluid it has proved highly effective. Winthrop-Stearns, Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 112)

Product Literature

- The control of insect infestations in institutions is the subject of an 8 page folder issued by West Disinfecting Co., 42-16 West St., Long Island City 1, N. Y. A three-step program for economical control of insects is discussed in the folder which also gives information on equipment, installations and minimum quantities of insecticide needed to rid various sized areas of flying and crawling insects. (Key No. 113)

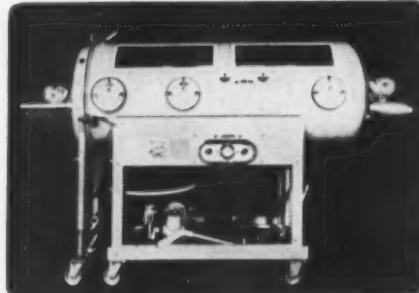
- Methods of x-ray protection and light-proofing are discussed in Catalog No. 53 recently issued by Ray Proof Corporation, 513 W. 54th St., New York 19. Details and specifications are covered on various phases of the problem. The book, which is plastic bound to lie flat when open, illustrates each specification by a plate with line drawings of structural details. It is a comprehensive manual for administrators, architects, engineers and others concerned with this problem. (Key No. 114)

- Quantity recipes for the new "Soufflé Salads" developed by General Foods Corp., Consumer Service Dept., 250 Park Ave., New York 17, are now available from the company. These appetizing, inexpensive additions to the menu can be prepared in a relatively short time. (Key No. 115)

- Bulletin No. 126, issued by Barnstead Still & Sterilizer Co., 2 Lanesville Terrace, Forest Hills, Boston 31, Mass., gives detailed information on mixed-bed water demineralizers. Special stress is laid on the recent development of the Barnstead simplified, positive regeneration system for quickly separating resins and then remixing them for efficient mixed-bed performance. (Key No. 116)

- A new comprehensive 54 page catalog of B. F. Goodrich Rubber and Koroseal Sundries is now available from B. F. Goodrich, 1247 S. High St., Akron, Ohio. The complete sundries line is shown, with prices, in the new catalog with many items pictured in full color. It is indexed by subject for quick reference and various packaging units are shown. Items covered include surgeons' gloves, baby pants, surgical tubing, syringes, rubber bands and water bottles, among others. (Key No. 117)

- Full color illustrations are used to depict the boxes of "Ready-Cut Portion-Control Meats" discussed in the folder released by Colonial Beef Co., 401 N. Franklin St., Philadelphia 23, Pa. Seventeen items in 95 different sizes are shown, together with pictures of the plant, pertinent information on the methods of operation of the company, and prices of the meats per serving and per box. (Key No. 118)



LEARN WHY DRINKER-COLLINS DUPLEX GIVES DOUBLE VALUE

Not every hospital can afford two respirators—but if you specify a Drinker-Collins Duplex, you will have the equivalent of two respirators at the price of only one. One Drinker-Collins Duplex can treat TWO children in an emergency and save a second life while another machine can be obtained later.

NEW FREE BOOKLET

Printed in four colors it pictures the important features of the Drinker-Collins Duplex Respirator. Advantages of the sloping front panel, patient comfort, equipment and all other accessories for patient comfort and easier nursing care are pictured and described. The new juvenile model is also shown. You receive a 32 page booklet, for it shows the very latest developments in Iron Lung construction and design.

ASK FOR BOOKLET M

WARREN E. COLLINS, INC.
Specialists in Respiration Apparatus
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Show Aug. 31
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Twin
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WRINGER, INC.
High-Grade Mopping Equipment

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P. O. BOX 658, MUSKEGON, MICHIGAN

Please send me complete information on

- All Geerpres floor-cleaning equipment.
- Geerpres "Floor-King" (24 to 36 oz. mops) with
 - single or twin tank.
- Geerpres "Floor-Prince" (16 to 24 oz. mops) with
 - single or twin tank.
- Geerpres "Floor-Knight" (8 to 16 oz. mops).

NAME
COMPANY
AND
ADDRESS:

What's New . . .

- Color blocks of Vina-Lux flooring are reproduced in a new folder on "The New Wonder Floor" released by Uvalde Rock Asphalt Co., Frost Bank Bldg., San Antonio, Texas. The folder gives general information on this vinyl-asbestos flooring which rarely needs hard scrubbing, does not require waxing, gives safe footing and offers cushioned resiliency for added comfort under foot. The line is available in brilliant colors which last the lifetime of the flooring. (Key No. 119)
- The Scientific Products Division of American Hospital Supply Corporation, Evanston, Ill., has issued its first product catalog. Devoted exclusively to the needs of clinical laboratories, the 300 page catalog lists all of the supply, equipment and specialty items necessary to outfit and sustain a clinical laboratory. Products are listed alphabetically and numerically for easy reference and a "Quick Index" front section supplements the more comprehensive back index section. A special section gives complete listing of laboratory chemicals. (Key No. 120)
- Bulletin No. A-104 issued by Eclipse Fuel Engineering Co., 1001 Buchanan St., Rockford, Ill., gives full catalog information on Eclipse Super-Matic Scotch "Steamboilerplants." Printed in color, the catalog illustrates and describes parts and operation. (Key No. 121)
- Design and operation of automatic water softeners equipped with pilot operated, diaphragm-type hydraulic valves is described in Bulletin 612 issued by Elgin Softener Corporation, Elgin, Ill. (Key No. 122)
- Many new laboratory instruments developed by Nuclear Instrument & Chemical Corp., 229 W. Erie St., Chicago 10, are described and illustrated in the new Catalog M recently released. One section is devoted to information designed for new workers using radioactivity. The company has recently announced the new trade name, Nuclear-Chicago, to avoid confusion with other companies in the same field. (Key No. 123)
- Information on the "2 Jewett Space Saving Cylindrical Blood Bank Refrigerators" is presented in a folder so entitled, issued by The Jewett Refrigerator Co., Inc., 2 Letchworth St., Buffalo 13, N. Y. Showing how floor space is saved with this equipment, and the operation of the adjustable revolving bright wire steel shelves, the folder indicates the capacity of each of the two models and discusses the dual controls which keep the units operating efficiently. Also described in the folder are the Jewett Counter-Type Blood Bank Refrigerators and a partial list of hospitals using Jewett Blood Banks is shown on the sixth page. (Key No. 124)
- A new booklet on the use of **Cramores Crystals** in quantity cooking is now available through Cramore Fruit Products, Inc., Point Pleasant, N. J. Designed to assist in improving, varying or budgeting meals for large numbers of people, the booklet contains recipes compiled by a hospital dietitian and other authorities, featuring citrus fruit-flavored dishes. Although the emphasis is on desserts, there are also suggestions for salads, sauces and vegetable dishes and a complete array of beverages. (Key No. 125)
- **The Trane Air Conditioning Manual** is a 380 page, board-bound book published by The Trane Company, La Crosse, Wis., in the interests of the air conditioning industry. This new edition is the sixteenth printing and second major revision of the work since 1938. The manual is designed to be used as a standard text and source reference on air conditioning in educational institutions and also as a reference manual for administrators, architects and engineers concerned with air conditioning. A new chapter on fans has been added to the book to cover fan application and selection, basic fan laws and duct design data and nomenclature. The manual is available at \$5 per copy and copies of the new fan chapter are available separately at one dollar each. (Key No. 126)



FOR CHURCHES, CONVENTS, MOTHER HOUSES, RECTORIES, SCHOOLS, SEMINARIES AND HOSPITALS

Ideal for rooms where prayer predominates. Especially suitable for quiet rooms provided for the mothers and children in churches. Kneeler is attached to legs with swivel bolts — can be folded back when not in use. Padded

with latex or felt, upholstered in Naugahyde, either standard or elastic grade. Solid Birch hardwood construction; saddle seat; reinforced stretchers and seat corners; metal cushion glides. Send for Bulletin PC 53.

SPECIFICATIONS

No. 5018 PRAYER CHAIR
Overall height—33"; Seat:Width—
16½"; depth—16"; height—18"

No. 4018 CHAIR

Identical to No. 5018, but with
out kneeler.

EICHENLAUBS
For Better Furniture
3501 BUTLER ST., PITTSBURGH 7, PA.
ESTABLISHED 1873

PEQUOT MILLS

"Sheets and pillowcases only—for every use!"

General Sales Office

EMPIRE STATE BUILDING, NEW YORK 1, N.Y.

BOSTON • CHICAGO • DALLAS • PHILADELPHIA • SAN FRANCISCO • WHITNEY, S.C.

What's New...

- The complete line of Nabisco individual service varieties available for institutional use is featured in a new booklet issued by National Biscuit Co., 449 W. 14th St., New York 14. Entitled "America's Home Favorites," the brochure shows each variety of the Nabisco institutional line in the newly designed package, together with hints for institutional uses. Information on new products, such as method of packing, cost per serving, count per pound and other facts of interest to buyers, are included. (Key No. 127)
- The Surgical Film Library of Davis & Geck, Inc., 57 Willoughby St., Brooklyn 1, N. Y., has published the 21st Edition of its catalog of "Films on Surgery" available to hospital and medical groups. (Key No. 128)
- A new folder on "Pure, Creamy Lobana," the antiseptic, protective massage cream produced by Ulmer Pharmacal Co., 1400 Harmon Place, Minneapolis 3, Minn., has recently been released. Information in the brochure includes how the product is made and packaged and the qualities that make the product desirable for hospital use. (Key No. 129)
- A revised list of MFMA approved floor finishing products is now available from the Research Dept., Maple Flooring Manufacturers Association, 35 E. Wacker Drive, Chicago 1. All floor finishing products on the list have been examined under new specifications and include both the penetrating sealer and bakelite type floor finishing products. (Key No. 130)
- Two booklets of interest to the maintenance department, service department, engineer and student, are offered by Simpson Electric Co., 5200 W. Kinzie St., Chicago 44. "1001 Uses For the Model 260" gives information on the Simpson Model 260 volt-ohm-milliammeter which will read electrical quantities of voltage, current and resistance. The 50 page booklet is profusely illustrated and offers detailed data on technical features of the Simpson Model 260. The second booklet, "How to Use the Simpson Models 479 and 480 for UHF Alignment," is a 38 page technical booklet for engineers and engineering students. (Key No. 131)
- The new "66" series of National Gas Boilers for institutional applications is described and illustrated in Catalog No. 607 issued by the National Radiator Co., Johnstown, Pa. Drawings of control systems for both hot water and steam installations, table covering boiler horsepower, I-B-R ratings and A.G.A. input and output ratings for natural, mixed and manufactured gas and automatic controls furnished with the cast iron boilers are presented in the 6 page catalog. (Key No. 132)

THIS COUPON is provided for your convenience in requesting additional information.

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Holophane Company, Inc., 342 Madison Ave., New York 17, manufacturer of lighting equipment, announces the opening of a new Engineering Center at Newark, Ohio. The new center provides the latest in accurate testing of the most modern lighting units with photometric, visual evaluation and general testing laboratories.

Hyland Laboratories, manufacturer of hospital solutions, announces change of address from 4534 Sunset Blvd., Los Angeles 27, to 4501 Colorado Blvd., Los Angeles 39, Calif.

Thonet Industries, Inc., 1 Park Ave., New York 16, manufacturer of furniture for schools, hospitals, hotels and stores, announces the opening of a new show room at 321 N. Robertson Blvd., Los Angeles, Calif. The opening of the new show room coincides with the 100th anniversary of the company in the United States which is being celebrated this year.



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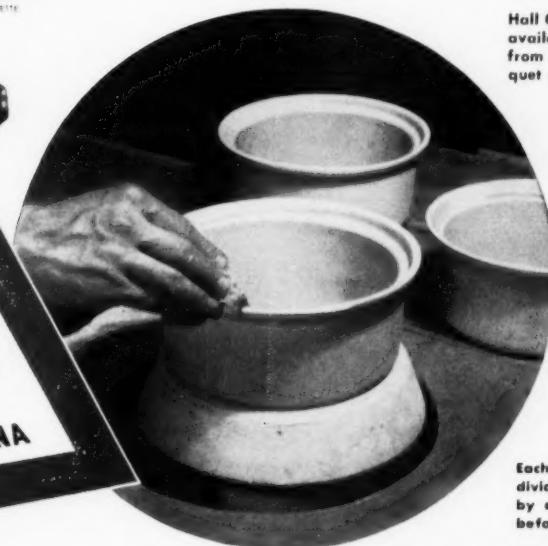
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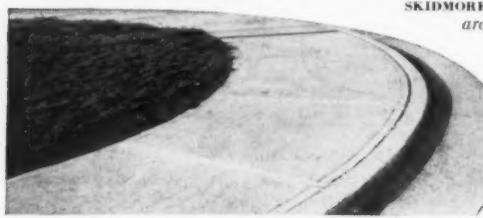
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